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# **Chapter 1**

## **Introduction**

### **1.1 Research Problem**

The research problem of this study is to contribute to evidence about identity growth during the process of bereavement, and to a growing but still limited understanding of how Narrative Therapy may facilitate this process, by examining how this growth ensues from therapeutic intervention in a psychology private practice.

### **1.2 Objective of the Research**

The aim and intention of the research is to study the therapeutic benefits of Narrative Therapy to grieving clients in a psychology practice. The research aims to elucidate the identity growth that can potentially take place through the very upsetting life experience of bereavement, and whether Narrative Therapy as therapeutic model may be used to facilitate this process, in addition to the therapeutic comfort that this approach may bring in this time. The study's potential contribution is both to the improvement of bereavement counselling practice, as well as its theoretical contribution about this particular therapeutic model and grief.

The research furthermore assesses the practical benefits in terms of emotional wellbeing, identity shaping, and social, career and personal functioning, in a qualitative study of five clients in therapy for bereavement. A literature study into the relevant topics will form the theoretical setting for the practical analysis.

### 1.3 Motivation for the Study

Death is a reality of everyday life, yet is a topic that is shied away from. As the cultural practices in dealing with bereavement unravel, therapists today have an important role to play in healing and helping the bereaved. This study is deemed significant to further knowledge about the therapeutic processes in this field.

Narrative Therapy in particular has been chosen as therapeutic model for its compassionate support for maintaining a relationship with the deceased. This can be seen through specific therapeutic tenets such as the practice of 're-remembering' where a loved one who had died can be re-incorporated in the circle of those that love him or her. Therapy is built on stories or narratives consisting of the memories and descriptions of shared histories and relationship. These memories are kept alive and remembered also for future generations who may not have known the person. What was especially appealing to me is Narrative Therapy's respectful, democratic and collaborative engaging with the client who is viewed as perfectly capable of healing and growth through discovering richer and 'thicker' narratives and the encouragement for re-scripting of their stories. Furthermore, Narrative Therapy appeals for its recognition (through the acknowledgment of the multiplicity of stories) of the complexity of relationships and emotions, and for the recognition that identity and meaning can be enriched and expanded through this process.

Therapy in my book is about growth, and that provided the final motivation for my choice of Narrative Therapy – in the creative space formed between therapist and client growth can take place, new insights may be gained, the 'narratives thickened', the dominant voices identified and the self-redefined (through the use of narrative tools such as journal writing, the creative use of language and so on.) This is why the postmodern context of therapy today is so important to me – my style as therapist is not a listing and eradication of symptoms. Nor is the therapist the expert who knows all the answers. From the perspective of Narrative Therapy, and my own, the therapist facilitates a process of healing with respect to the client's own wisdom.

In the numerous studies read about grieving and grief therapy, relatively little mention is made of the growth that takes place in the person, the growth also in identity. As one can imagine, as a person's role changes from daughter to woman, or wife to widow, identity changes. But more so, as a person grapples with the heartache and the gamut of emotions after the loss of a loved one, changes in role encourage different facets of the character to come to the fore. New talents may be discovered such as becoming a capable care-taker in the family, or discovering unexpected resilience in dealing with setbacks. Therefore, as a Narrative Therapist, my hope is to facilitate this process in such a way that by the end of therapy a bereaved person will have a more clear understanding of their core values, their role in their family, what they are hoping to create in their future, a sense of purpose, and a better sense of self.

The study furthermore aims to expand the body of knowledge about the efficacy of Narrative Therapy in general in times of bereavement. According to Biggs & Hinton-Bayre (2008) there is a great paucity of published outcome Narrative Therapy research, possibly because narrative approaches to therapy are naturally better suited to a qualitative approach, and because of the "position narrative therapy takes against empiricism, standardised measurement, manualised treatment and quantitative analysis" (p. 6). It is my hope that a properly devised qualitative study would contribute to the field, not just in 'assessing outcomes' but more importantly in broadening the qualitative understanding of narrative counselling of bereaved persons.

#### **1.4 Design of the Study**

Five participants were purposefully chosen for their struggle in dealing with loss and bereavement. Qualitative research based on a Case Studies research design is utilised to obtain a full and rich description of the grieving experience through the narratives of the bereaved. A descriptive model is used which allows the researcher to be both therapist and data-collector which enables inquiry and theorising to take place whilst therapy is in



progress. The therapist first and foremost provides a therapeutic space for the bereaved to tell the story of their grief, their loss, their love or other emotions for the those who died and any other memories that naturally surface. As a Narrative Therapist, specific therapeutic guidelines are followed to assist the grieving person not just to heal, but also potentially to grow from the grief experience. An in-depth longitudinal study is done of the therapeutic process and descriptions are given of the experience by both the participants and therapist, where after the data is systemically organised and cross-referenced to extract themes that may arise that are common to some or all of the participants.

## **1.5 Chapter Review**

**Chapter 2** follows from this chapter and expands on the research design, addressing aspects such as the research methodology, hypothesis, sampling, data collection, trustworthiness and reliability, and ethical considerations. It explains why qualitative research and case study research was chosen as descriptive research model. The chapter concludes with the theoretical framework that forms the basis for the study and discusses Social Constructivism and Post-modernism.

**Chapter 3** provides a thorough exposition of grief and grief counselling through the ages and as social constructs in a variety of cultures.

**Chapter 4** explains Narrative Therapy including the main therapeutic tenets, the role of the Narrative therapist and how Narrative Therapy fits in the arena of Postmodernism and Social Constructivism.

**Chapters 5 to 9** incorporate the five case studies providing a rich description of the participants' background, the individual therapeutic processes and the identity growth that each experienced.

**Chapter 10** provides a comparative analysis of the themes that arose in the case studies. Narrative-inspired, qualitative research is an idiographic approach focussing on the subjective nature of experience. Thematic analysis is utilised as a method for identifying, analysing and reporting patterns (themes) within data. The information is triangulated and different data sources such as the therapist's observation, the self-stated outcomes of therapy by the bereaved respondents in the case studies, as well as other sources such as letters provide a rich description of the person's identity growth within the social context they find themselves in. Posttraumatic identity growth is described as it occurred through the tenets and methodologies of Narrative Therapy.

**Chapter 11** concludes the study by reflecting on the study as a whole, the strengths and limitations of the research, and possible recommendations for future research in the field.

## **1.6 A Personal Perspective**

Kilbourn (2006) notes that it is important to be aware of the researcher's own stories and histories and how this may contribute or detract from a study. The way in which we see and respond to a situation, as therapist and researcher, and how we interpret what we see, will necessarily bear our own signature.

I remember pondering why I was so drawn to this study at the onset. Why I was willing to put so many hours, days, weekends, years of my life into this study, and why it kept drawing me back even when I was experiencing an overflow of distracting circumstances in my life throughout. In my practice I had been blessed by a variety of therapeutic experiences and have always been impressed by the resilience of the human spirit, and how humans sometimes don't just overcome the pain of experiences such as loss, but actually go beyond and grow directly as a result of their pain and loss. Shortly before I

made the final decision about the topic, my mother was diagnosed with congestive heart failure. Such a small sentence hiding so much fear, tears and worry, and I learnt later, so much anticipatory grief. The spotlight of my attention was quite naturally drawn to grieving persons, and how they coped. Combined with the content of grief, and my natural high life value on learning, the fate of the study was sealed. Why Narrative Therapy? Because I believe that it is the most natural way of being with loss, we naturally tell stories about people we love, we naturally remember even more of our shared histories when someone dies, we may choose to re-incorporate (or not) the loved one in the new social system and if we do things right, we may even grow. Furthermore, it seems not just natural but obvious that our grief is socially constructed.

Why a qualitative study when our Western world seems so pre-occupied with numbering, measuring and quantifying, seemingly placing a much higher value on quantitative than qualitative research? Is every one's grief the same? Is any person's love the same? Are all our histories the same? Or for that matter our identities? Can one truly quantify identity or growth in a number assigned to a list of descriptive adjectives? Surely not. Not to me anyway. As a psychologist working for many years with individuals with their own in-depth life experience, this was natural to me. For another researcher it might well be different and valuable insights might be gained. For this particular researcher and therapist, I saw my role as a healer with the privilege of being a part of a person's journey at a very specific junction in their lives. And I remain deeply respectful of the depth and highly nuanced experience of what it means to be human with all the many choices of responding to trauma that that entails.

## Chapter 2

### Epistemological Framework and Research Design

#### 2.1 Epistemological Framework

##### 2.1.1 Introduction

Epistemology is the study of knowledge, especially with regard to its methods, validity, and scope, and the distinction between justified belief and opinion. The Merriam-Webster Dictionary defines it as ‘the study or a theory of the nature and grounds of knowledge especially with reference to its limits and validity.’ The word derives from the Greek ‘epistēmē’ meaning ‘knowledge’ and ‘logos’ meaning ‘word’. If one considers that the stories or narratives told by a client to a therapist, and by a researcher in a thesis or research report, are expressed through words, it is quite apt. The American Heritage Dictionary of the English Language note that epistemology implies the examination not only of the nature of knowledge, but also its presuppositions and foundations, as well as its extent and validity. Epistemology also holds the word ‘epistanai’ which means ‘to understand’, most surely the aim of this study. A fundamental assumption for any academic research is that the phenomena that one wishes to understand are filtered through a point of view, that is, a theoretical perspective. It is therefore particularly important to clarify and delineate the underlying assumptions that the study is scaffolded on.

Robert MacIntosh (2009) emphasises the importance of distinguishing between: *methodology* which has to do with the tools and techniques of research; *ontology* which is about our assumptions about how the world is made up and the nature of things; and *epistemology* which has to do with our beliefs about how one might discover knowledge about the world. He notes that the epistemological and ontological positions the researcher holds should have some bearing on the methods that one selects for the research. Darlaston-Jones (2007) concurs “The ability to identify the relationship

between the epistemological foundation of research and the methods employed in conducting it is critical in order for research to be truly meaningful” (p. 19).

To this end, this chapter makes plain the *epistemological underpinnings* for the study: Postmodernism including what it means to see oneself as a postmodern psychologist and grief counsellor; and Social Constructionism which emphasises that practices such as grieving or how a human makes meaning in his world is always influenced and relative to socio-cultural-historical-temporal contexts.

“...it can be argued that the use of qualitative methodologies is predicated upon social constructionism and the adherence to a social constructionist philosophy requires the use of qualitative research methods” (Darlaston-Jones, 2007, p. 25). The natural relationship between qualitative data collection methods such as interviews and a social constructionist epistemology rests upon the acknowledgement that as researchers our role in the research process is as co-constructors of reality. As researchers, if we’re honest, we bring to our research our worldviews complete with bias and prejudice – it is not possible to separate the me from the research. “The research process then becomes one of co-construction: in partnership with our respondents we create an interpretation of his or her reality” (p. 25).

And so, from these presuppositions of knowledge, the *methodology* follows the case study as research method. Narrative research as a qualitative research model is used and the thematic content analysed according to the steps suggested by Miller and Crabtree’s ‘Dance of Interpretation’. Qualitative research methodologies are able to extract the degree of detail often obscured by more traditional, positivist methods. They provide the means to seek a deeper understanding and explore the nuances of experiences not available through quantification. “By utilising these methodologies we are able to expand on the ‘what’ questions of human existence asked by positivism to

include the ‘why’ and ‘how’ questions asked by constructionism” (Darlaston-Jones, 2007, p. 29).

As for *ontology* – well, as a postmodern, social constructivist researcher I have to concede that I cannot have anything definite to say about the ultimate nature of reality. By definition in my opinion knowledge is co-created and sometimes we have consensus as cultures or nations about what we view as a common sense understanding of what reality is. Whether anybody can have the final say about that, I simply do not know. My aim as researcher is to understand the view of the world by those who live and breathe in it, love and grieve in it. I’d rather maintain a respectfully humble stance about the ultimate nature of reality, and leave it at that.

## **2.1.2 Postmodernism**

### **2.1.2.1 What is Postmodernism?**

If Modernism was characterised by faith in inevitable social, scientific and technological advancement, urbanisation, industrialisation and the blossoming of capitalism, then Postmodernism takes a humbler approach, no doubt influenced by the experiences of the Second World War – scepticism of inevitable grand narratives, Enlightenment rationalism, and ideologies based on ‘absolute truths’ (Duignan, Encyclopaedia Britannica, 2014).

Postmodernism denotes not only a period but also a set of ideas, and can only be understood in relation to the preceding period and ideas of that time – Modernism. Modernism was an equally diverse art and cultural movement in the late 19th and early 20th centuries. The term ‘avant-garde’ epitomised the new and even surprising ideas that were developing in art, literature and so on. The common theme was a break with tradition, epitomised by the American poet Ezra Pound’s 1934 injunction to ‘make it new!’. As an interesting side-note, Stobaugh (2014) makes the observation that Pound is

a good example of the paradoxes inherent in Modernism: as much as Pound embraced a new understanding of human liberty and free expression, he also paradoxically embraced nascent nationalism and anti-Semitism (Stobaugh, 2014).

Postmodernism is characterised by a questioning of the ideas and values associated with a form of modernism that believes in almost inevitable progress and innovation. The Encyclopaedia Britannica defines Postmodernism very well: it is 'a late 20th-century movement characterized by broad scepticism, subjectivism, or relativism; a general suspicion of reason; and an acute sensitivity to the role of ideology in asserting and maintaining political and economic power.' (Duignan, 2014). Hatuka and D'Hooghe (2007) state that Postmodernism involves theories that embrace and aim to create diversity, and it embraces uncertainty, flexibility and change. It is expressed in art, architecture, literature and even urban planning.

Postmodern influential thinkers include Martin Heidegger who rejected the philosophical basis of the concepts of subjectivity and objectivity and asserted that similar grounding oppositions in logic ultimately refer to one another, which should be embraced through his concept of the Hermeneutic Circle. Heidegger stressed the historicity and cultural construction of concepts. The French philosopher Jacques Derrida who is most known for the development of semiotic deconstruction of texts, saw himself as a historian and questioned assumptions of Western culture and Western philosophical tradition. Derrida's most quoted and famous assertion is the statement that 'there is no out-of-context' (Butler, 2002).

Michel Foucault focussed on the ways in which accepted social and psychological constructs can foster cultural hegemony, violence and exclusion. Jean-Francois Lyotard opposed assumptions of universality, consensus, and generality and is best known for his articulation of Postmodernism after the late 1970s and the analysis of the impact of postmodernity on the human condition. His book, *The Inhuman*, was published in 1988,

in which he illustrates a world where technology has taken over. Lyotard's thoughts about epistemology were that modern philosophies legitimised their truth-claims not on logical or empirical grounds, but rather on the grounds of accepted stories, or metanarratives, about knowledge and the world. He argued that in our postmodern condition, these metanarratives no longer work to legitimise truth-claims. From another continent, Richard Rorty was an American philosopher who rejected the tradition of philosophy according to which knowledge involves correct representation (a 'mirror of nature') of a world whose existence remains wholly independent of that representation (Butler, 2002; Blatner, 2002).

It seems clear that a theme throughout with these thinkers is a tendency for scepticism of knowledge that is objective and absolute and rather, that ideas are viewed as being social constructions (Blatner, 2002).

### **2.1.2.2 Epistemology from a Postmodern Perspective**

It was Friederich Nietzsche, who said, 'all knowledge is perspective'; and 'there are no facts, only interpretations' (Nietzsche, 2000). Reflecting this disenchantment with Rationalism further: "Over immense periods of time the intellect produced nothing but errors. A few of these proved to be useful and helped to preserve the species: those who hit upon or inherited these had better luck in their struggle for themselves and their progeny. Such erroneous articles of faith... include the following: that there are things, substances, bodies; that a thing is what it appears to be; that our will is free; that what is good for me is also good in itself" (Nietzsche, 1974, p. 169).

Postmodernism asserts that knowledge is the product of unique systems of social, historical, and political discourse and interpretation, and is therefore always contextual and constructed. Therefore, it would be fair to say that postmodern thought tends to epistemological relativism, scepticism, subjectivity and self-referentiality.



In an epistemological sense we may ask 'what is knowledge?', 'what is real?', 'how do we know what we know?' The answers have become relative and complex. Post-modern humans can no longer draw on or accept opinions by respected citizens of society as obvious and eternal truths. So, scepticism, making up your own mind, and conversely, a throwback to holding on to old 'truths' have become the norm.

Blatner (2002, para. 11) puts it beautifully: "Well, truth is a bit like the apparent solidity of objects. If you get up close enough, many objects are more porous than they appear, and at the atomic level, there is apparently a great predominance of space with active energies operating within that space, sort of like the way propellers seem to generate the appearance of discs. Similarly, when any truth is probed carefully, it becomes more porous, relative to circumstance, frame of reference, and constructed often largely in terms of language. Those truths that seem more rooted in basic fact often are in themselves lacking in much significance - the meaning is then superimposed, and depending on the meaning-makers, there may be a number of possible interpretations."

### **2.1.2.3 On Being a Postmodern Human**

I think it's easier to believe in absolute 'truths', objective, eternal 'truths'. It guides thoughts and actions and societies and the individuals in them know their place, life is more predictable and feels more certain. And yet, as a postmodern human myself, I know that I don't prefer such a world. Why would that be? Because intuitively I know that it limits freedom, that it has the potential to bring about harsh judgement, that it can disenfranchise groups who are not seen as complying with the upheld norm of what should be. So, it has become the task of a postmodern human, at least those that live in relatively free thinking societies, to make up their own minds, to decide for themselves what they want to believe in terms of metaphysics or politics or morality. We live in a world so full of knowledge that it has become as easy as picking up your phone to google a recipe or natural treatments for cancer. Postmodern humans don't have to ask their

mom for that recipe anymore, or vote for the same political party as their parents. It is an open question whether this is beneficial for us or not. The responsibility for our choices has now become our own. Morality is no longer accepted from religion; many postmodern humans view it as something they have to figure out themselves. Of course, most of us have a tendency to want to conform and to not stray too far from the norm, at least for a sense of belonging to a group.

In Modernism, sometimes called Enlightenment Humanism, 'truth' exists independent of human consciousness and can be known through the application of reason. The belief is that the application of reason necessarily leads to a progressive movement toward civilisation, democracy, freedom and scientific advancement, and thus a better society. Incidentally in this view, women may attain respect in society only as much as they become reason-able.

Postmodernism is distinctly less optimistic – 'truth' may exist independent of human consciousness but there is no objective means of getting a full grasp on it. Therefore, there is no objective means upon which to predicate morality or a just society. Concepts such as masculine and feminine are culturally constructed and gender roles are culturally constructed and thus relative in all cultures and contexts (Faigley, 1992).

For Jean-François Lyotard, postmodernity potentially offers a new and better ground for the practice of democracy and justice. In *The Postmodern Condition: A Report on Knowledge* he argues that postmodern heterogeneity makes the Enlightenment ideal of consensus obsolete, which all too frequently required the suppression of minority dissent. Postmodernity, with its heterogeneous interests and worldviews, allows previously oppressed or marginalised groups to make claims upon justice and recognition not afforded in Modernism. Postmodern humans at their best have the potential to become sensitive and respectful of cultural, personal and gender differences and reinforce our ability to tolerate or even celebrate these differences.

In a book published in 2015, *Excellent Sheep*, the author William Deresiewicz criticises the obsessive pragmatism and money worship that's come to define the Ivy League experience. Deresiewicz notes that postmodern society has reduced what it means to be human to market terms, by becoming sceptical of institutions of culture whose job it is to speak for other values like learning for its own sake, or beauty or justice or truth. He laments postmodern society's over focus on market values and believes postmodernism costs us dearly in terms of what he believes really makes us human by allowing our only guideline our ability to make money.

In my view, humans have the potential to transform any worldview into something that serves or detract from society and morality. Postmodernism is no different. Does the freedom to make up your own mind and not draw on set truths or previously cherished cultural or religious views bring the potential for anxiety and a sense of being adrift? Undoubtedly. Did we gain some humility from a cultural and rational intellectual standpoint? I should hope so.

#### **2.1.2.4 Postmodern Psychology**

*Postmodern Psychologies, Societal Practice and Political Life* (Holtzman & Moss, 2000) is well worth a read on the subject of postmodern psychology. The writers note the breakdown of the previous Modern dichotomies such as between objective reality and subjective interpretation, self and other, cognition and emotion. What it means for this study and for psychologists in general is that we can discuss what our clients bring us and what their experience of the world mean to them, but we cannot 'measure' it against an objective or 'real' world.

Postmodern psychologists point out that the dominant psychological model of human beings (and how to study and help them) "distorts not only the complexity of human life

but also its unique self-reflexivity and sociality” (Holtzman & Moss, 2000, p. 6). Postmodern psychology therefore challenges the Modernist view of psychology as the science of the individual, in favour of seeing man as a cultural being. Most pertinent to this study, the editors of the book note that traditional Modernist psychological models do not take into account “what many psychologists take to be the human need and capacity for positive and qualitative growth or what others see as the essential relationality of human life as lived” (p. 6).

#### **2.1.2.5 Postmodern Grief Counselling**

Postmodern grief counselling favours a more democratic style of therapy, and a move away from a schismatic, reductionist and dare I say disrespectful view of the clients we engage with. In fact, third wave therapeutic models (and beyond) see the therapeutic exchange as one in which meaning is co-created, and healing takes place in the therapeutic relationship which is marked by kindness, recognition, patience and human contact. This brings about a more tender view of the human condition through unconditional positive regard and recognition of meaning and value (and sometimes spirituality) as experienced by the individual. What matters to the client matters to the therapist.

Evans describes the role of the therapist as such: “There has also been a subtle shift with respect to the role of the change agent. In the early model, the change agent is external to the system, and someone who acts upon the system. The later views include a view of inclusiveness and reciprocity, the notion of ‘being with’ rather than ‘doing to’ and the notion that the therapist and the patient/client are together a part of a greater whole. On the way to complexity and emerging from systems approaches, is the fourth wave which comprises various constructivist influenced therapies, principally Narrative and Solution Focused therapies” (Evans, 2003, p. 9). O’Hanlon (1990) agrees and notes that therapy becomes a collaborative affair with both client and therapist seen as experts in a collaborative process based on possibilities and solutions using collaborative language systems.

### 2.1.3 Social Constructionism

Humans have told their stories probably for as long as language has existed, it is an essential expression of being human and much of our social constructions are expressed this way (Pompa 1982). History is not some kind of unfolding or evolving process that is external to human affairs, he notes. Men and women make their own history.

Social constructionism refers to the development of phenomena relative to social contexts while social constructivism refers to an individual making meaning of knowledge within a social context. Andrews (2012) writes that while constructivism proposes that each individual mentally constructs the world of experience through cognitive processes, social constructionism has a social rather than an individual focus and is interested in the process by which meanings are created, negotiated, sustained and modified. Andrews argues that Social Constructionism arose as a challenge to scientism and has been influenced by the post-modernist movement.

In 1966, a book was published by Peter L. Berger from Boston University in America, and Thomas Luckmann originally from the University of Constance in Germany and later Stanford in America, called *The Social Construction of Reality*. The book was listed in 1998 as the fifth-most important sociological book of the 20th century by the International Sociological Association. One of the main tenets of the book is that people and groups interacting in a social system over time create concepts or mental representations of each other's actions, and that these concepts eventually become habituated into reciprocal roles played by the actors in relation to each other. Meaning, concepts of reality and habits become embedded as social constructs in society. Social constructs, such as grief, grief practices and how to grieve, are notions that appear to the members of the particular society as natural and obvious, but may or may not represent reality, and it remains largely an invention or artifice of a given society (Ozor, 2008;

Berger & Luckmann, 1966). The relationship of Social Constructionism with Narrative Therapy will be elaborated on in Chapter 4.

In terms of knowledge, and how Social Constructionism informs how we do research, a few points:

Darlaston-Jones (2007) agrees with Andrews (2012) that Social Constructionism embraces the postmodernist view that incorporates the role of context in the construction of identity. Multiple perspectives on an issue or topic provide the researcher with a varied understanding of how that issue appears to different people as a result of their different interpretations of the issue. Constructionists view knowledge and truth as created and not 'discovered by the mind' as modernists would see it. Andrews (2012) maintains that this knowledge still corresponds to something real in the world. From this perspective, reality is socially defined and refers to the subjective experience of everyday life, how the world is understood rather than to the objective reality of the natural world. He references Steedman (2000) who noted that most of what is known and most of the knowing that is done is concerned with trying to make sense of what it is to be human, as opposed to scientific knowledge. Therefore, our reality is defined and described by individuals or groups of individuals.

"Constructivist approaches to therapy adhere to the doctrine that one cannot ever truly know reality. As such, strict narrativists do not conceive of an objective reality, but rather to the infinite ability of the person to deconstruct and reconstruct a new reality" (Biggs & Hinton-Bayre, 2008, p. 17). Crabtree and Miller (1999) make an important distinction between Constructivists claim "that truth is the result of perspective; it is relative (...and) there is no objective knowledge" (p. 10) versus Interpretivists' point of view that also recognises the importance of the subjective human creation of being without outright rejection of the notion of objectivity. Interpretivists trace their roots back to phenomenology and the hermeneutics of Heidegger. Interpretivists prefer pluralism rather than relativism "with focus of the circular dynamic tension of subject and object" (p. 10). The authors' preference, which resonate with my own, is to take a

more pluralistic approach with what they term 'constructivist inquiry' because what is under study is human constructions and because the researcher co-creates constructions. Andrews (2012) argues that the debate between whether Social Constructionism is based on relativism rather than realism is a moot point - it is concerned with how knowledge is constructed and understood and therefore it has an epistemological not an ontological perspective. He argues that as for ontology and the search for a final, absolute truth - that is best left to philosophers and theologians.

Berger and Luckmann (1991) in Andrews (2012) note that conversation is the most important means of maintaining, modifying and reconstructing subjective reality. Subjective reality is comprised of concepts that can be shared without difficulties with others. In other words, there is shared meaning and understanding, so much so that concepts do not need to be redefined each time they are used in everyday conversation and come to assume a reality which is by and large taken for granted. Jackson and Sorensen (2007) agree that human beings rely on 'understanding' of each other's actions and assigning 'meaning' to them. They discuss Immanuel Kant who was one of the forerunners for social constructionism's point that though we can obtain knowledge about the world, it will always be subjective knowledge in the sense that it is filtered through human consciousness. So, in order to truly understand human interaction, we cannot merely describe it in the way we describe physical phenomena, such as a boulder falling off a cliff; we need a different kind of interpretive understanding, or '*verstehen*'.

From this follows that research from a Social Construction perspective will always aim to describe and to understand, rather than have the final word. Margaret Roller on her excellent website Research Design Review, puts it this way: "Social constructionism and qualitative research is a natural marriage, wedded by a mutual respect for the complexities of the human experience and the idea that any one facet of someone's life (and the researcher's role in exploring this life) intertwines with (contributes to) some other facet. That, as human beings we can't be anything other than intricately involved together in the construction of our worlds" (par. 3). Can a theoretical framework such as

Constructionism that holds in its essence concepts such as the importance of context; the importance of co-constructed meaning, flexibility of research design and a participant-researcher relationship lead to useful outcomes? She very much believes so, and notes that if done well, this kind of research can celebrate complexity, multiplicity, flexibility, diversity, 'irrationality' and contradiction in a way that is fruitful and useful. Margaret Roller (2015) designed the Total Quality Framework with her co-author, Paul Lavrakas in their book, asking the researcher to think carefully about design-implementation considerations such as: the range of people who are included (and excluded) from participation, researcher training and data gathering techniques, analytical and reflective processes, and the transparency of the reporting.

## **2.2 Research Design**

### **2.2.1 Hypothesis**

*Narrative Therapy can be of therapeutic value and can lead to growth and positive identity expansion in individuals experiencing bereavement.*

### **2.2.2 Research Aim**

The objective of the research is to study the therapeutic benefits of Narrative Therapy to grieving clients in a psychology practice. An attempt is made to provide a clearer understanding of how bereavement counselling can lead to growth and positive identity formation and not merely an eradication of symptoms. The research aims to elucidate this topic and assess the practical benefits in terms of emotional wellbeing, identity shaping, and social, career and personal functioning in a qualitative study of five clients in therapy for bereavement.

The study aims to expand the body of knowledge about the efficacy of Narrative Therapy in times of bereavement. According to Biggs & Hinton-Bayre (2008) there is a great paucity of published outcome Narrative Therapy research, possibly because of the



“position narrative therapy takes against empiricism, standardised measurement, manualised treatment and quantitative analysis” (p. 6). Narrative approaches to therapy are suited well to a qualitative approach. It is felt that a properly devised qualitative study would contribute to the field, not just in ‘assessing outcomes’ but more importantly in broadening the qualitative understanding of narrative counselling for bereaved persons.

### **2.2.3 Sampling**

Qualitative research follows a different logic from quantitative research and uses non-probability samples for selecting a population for study. Here the individual participants are selected deliberately for their specific characteristics that are of importance to the study and to answer the research question. Purposive sampling is therefore employed in this study. Purposive sampling has two principle aims: (a) to ensure that all the key characteristics of relevance to the subject under study are covered, and (b) to ensure that within each key criterion some diversity is included so that the impact of the characteristic concerned can be explored. Guba and Lincoln (1989) believe that maximum variation sampling, which surveys variations in order to target specific patterns, is the preferred strategy for constructivist inquiry. Therefore, persons will be selected to show a variety of grieving situations, i.e. the loss of a child, husband, father, death through suicide etc. The idea is to reflect the multiple facets of bereavement and the impact on individuals, and to describe this in detail – as it pertains to the individual situations, but also the commonalities that arise with the persons studied (e.g. common emotions) as common themes.

Ritchie, Lewis and Elam (2003) contend that qualitative samples are usually small in size, as the aim of this form of study is not to estimate the prevalence of a phenomenon but to provide an in-depth understanding of a topic, to develop explanations and to generate ideas or theories. They discuss three main reasons for this: “First if the data is properly analysed, there will come a point where very little new evidence is obtained from each additional fieldwork unit. This is because a phenomenon needs only to appear once to

be part of the analytical map. There is therefore a point of diminishing return where increasing the sample size no longer contributes new evidence. Second, statements about incidence or prevalence are not the concern of qualitative research. There is therefore, no requirement to ensure that the sample is of sufficient scale to provide estimates, or to determine statistically significant discriminatory variables. Third, the type of information that qualitative studies yield is rich in detail. There will therefore be many hundreds of 'bites' of information from each unit of data collection. In order to do justice to these, sample sizes need to be kept to a reasonably small scale" (p. 83-84).

### **2.3 Data Collection**

In a study like this where research happens concurrently with the process of therapy over weeks and months, a process of moment by moment gathering of data and theorising takes place.

Clients are encouraged to narrate their unique experience in as much detail as they feel the need to. This not only enables the researcher to gain a better understanding and richer data, but also provides a grieving person the opportunity to examine their feelings and thoughts and express what sometimes feelings like the inexpressible to the world at large. To gather information of the unique, subjective experience, questions posed during the therapy sessions should be as open-ended as possible. In fact, questions and reflections in therapy also aim to encourage respondents to communicate their underlying attitudes, beliefs and values that are unique to them as a person. The objective is to let the story or narrative reveal itself and how the person relates to it, rather than to determine the frequency of experiences or the generalisability of these experiences.

Robert K. Yin who wrote extensively and convincingly about case study research, defines the method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 1994). And that

is the strength of the data - case study research excels at bringing us to an understanding of a complex issue or subject and can extend experience or add strength to what is already known through previous research. The emphasis is on detailed contextual analysis of a limited number of grieving persons and their relationships.

Extensive note keeping during and after sessions provide the main source of data. This is augmented with written documents such as email correspondence with clients and letters written by clients to the person they had lost, and so on. The case notes include a description of the symptoms, the diagnosis, the treatment and eventual outcome but mostly contain details of the unique in the moment experience of the person, their memories and their hopes and aspirations for their own particular future. Extensive note keeping yield the opportunity to not only list superficial symptoms but also deeper and richer data such as the meanings that individuals assign to events, the complexity of their attitudes, behaviours, experiences and relationships.

In-depth interviews will be done at the conclusion of therapy to discuss themes that arose, how the person feels they benefitted from the therapy, what was learned, what was particularly helpful, how they see themselves after this process – whether they had discovered hidden strengths, talents or capabilities, or conversely weaknesses. In open ended questions clients may discuss more about what they had learned about their capacity in dealing with setbacks and losses and how therapy changed how they see themselves. They might also describe insights that came to the fore about their relationship with the deceased, other family members and so on. The interviews after therapy will be recorded (if permitted by the individual) and transcribed.

### **2.3.1 The Case Study as Research Method**

Case studies in Psychology has been used since the time of Freud to elucidate the unique experience of mental suffering. These in-depth descriptions make the text book description more real for students in Psychology and take it from a list of generic

symptoms to move something in the future clinician's heart and bring greater understanding. In research, case studies provide rich insight and depth of understanding that compliments the quantitative information yielded by studies of traits in large groups of people.

The information yielded through this method is mainly biographical and relates to retrospective events in the individual's past, as well as to significant events which are currently occurring in his or her everyday life. As such it provides not just a detailed and comprehensive profile of the person, but also the specific condition the researcher means to illuminate and explore. A case study yields the potential for nuanced information in real life circumstances described in depth. It may incorporate quantitative as well as qualitative data, though in this qualitative study the emphasis was on the unique, lived experience of the participants. Subjects to be studied in case study research are typically selected through information-oriented sampling, as opposed to random sampling, that is, subjects are chosen based on their specific case bringing insight into the subject matter and for the interesting case they present. By their very nature, case studies are ideographic - they focus on the individual case without reference to a comparison group. As a qualitative rather than quantitative investigation, case studies provide distinctive stories of an experience rather than the nomothetic, which seeks to provide more general law-like statements, usually by emulating the logic and methodology of the natural sciences (Hayes, 2000). Carla Willig (2001) distinguishes between 'Intrinsic case studies' that are chosen merely because they are interesting in their own right and without the need to necessarily illuminate a more general problem or phenomenon. 'Instrumental case studies' on the other hand, as in this study, constitute exemplars of a more general phenomenon. The cases are selected to provide the researcher with an opportunity to study the phenomenon of interest, such as bereavement, and how different subjects experience the phenomenon under investigation.

Ann Searle (2002) describes the limitations of case studies including the obvious fact that the results can not necessarily be generalised to the wider population. Because they are based on the analysis of qualitative (i.e. descriptive) data a lot depends on the emphasis the psychologist places on the information he or she has acquired. The findings may be difficult to replicate and there is a lot of scope for observer bias - it could be that the subjective opinions of the psychologist intrude in the assessment of what the data means, which even Freud was accused of. On the other hand, case studies provide detailed qualitative information and opportunities to shed light on aspects of human thinking and behaviour that would be unethical or impractical to study in other ways, for instance studying a child in depth who was found after years of neglect. She notes that research which only looks into the measurable aspects of human behaviour is not likely to give us insights into the subjective dimension to experience. Case studies yield in-depth information that may spark insight for further research.

In this study, five participants were purposefully chosen for their struggle in dealing with loss and bereavement. The aim was to provide a variety of circumstances during which the individuals experienced loss and grieving, providing a rich and unique description for each rather than focussing on commonalities per se. A special interest in the potential of the grief experience to bring about growth followed from the researcher-psychologist's previous observation in her practice of growth often following trauma and grief, and the interest was piqued to explore this topic in depth.

In the case studies research done here, an in-depth longitudinal study was done of the therapeutic process, a description given of the experience by both the participants and therapist, where after the data was systemically organised and cross-referenced to extract themes that may arise. A descriptive model is used which enables the researcher to be both therapist and data-collector. This allows inquiry and theorising to take place whilst therapy is in progress. Information is thus obtained through a process of active moment-to-moment theorising, data collection and content analysis during which it is

hoped that a sense of the therapeutic value of Narrative Therapy in bereavement will arise.

### **2.3.2 A Qualitative Study**

Conventional forms of research often search for empirical conclusions (as with quantitative designs) and typically rely on the researcher's expert role to collect, codify, and interpret data (as is the case with many forms of qualitative methodology). "...the modern science model brings with it the philosophical-methodological bias of modern epistemology; that is, that truth, reality, objectivity, causality, and duality are necessary premises of understanding" (Holtzman & Moss, 2000, p. 6). Qualitative research on the other hand is concerned with understanding the meaning of contingent, unique, and subjective experience, describing the experience of the individual who is seen as a unique agent with a unique life history, with properties setting him/her apart from other individuals. Case studies as a qualitative research model is an idiographic approach which allows a researcher to investigate a topic in far more detail than might be possible if they were trying to deal with a large number of research participants (nomothetic approach) which has the aim of 'averaging' and understanding commonalities within groups of people.

Narrative-inspired research focusses on the subjective nature of experience and seeks to de-emphasise the therapist's role as an expert. In particular, the narrative enterprise of co-research is often employed as a research method that is not only used to expound on the therapeutic qualities of the externalizing process, but is conducted with clients in an externalising manner of speaking (Epston, 1999). Bill O'Hanlon (1990) refers to 'iatrogenic healing' which according to him refers to those methods, techniques, assessments, procedures, explanations or interventions that encourage, are respectful and open up the possibilities for change.

This qualitative study is conducted where the efficacy of Narrative Therapy in terms of symptom reduction, but also in terms of growth and meaning-making, for persons suffering loss and bereavement was implemented and assessed. Case Study research entailing a phenomenological description of the process of therapy as well as the very individual descriptions of the therapeutic experience and outcome by the subjects themselves is done. The aim is to investigate whether Narrative Therapy is of value to the client as a therapeutic model for bereavement therapy. From a Constructivists perspective, this paradigm “recognizes the importance of the subjective human creation of meaning, but doesn’t reject outright some notion of objectivity. Pluralism, not relativism, is stressed with focus on the circular dynamic tension of subject and object” (Miller & Crabtree, 1999, p. 10). The aim is to elucidate, and better understand, the way people experience bereavement, how they position themselves in the face of the many emotions and tasks they have to go through as a consequence, and particularly how they change and grow as people through this process.

When working with a grieving person the awareness is there that this is a life in crisis. The shock and disbelief, the heartache and bewilderment are emotions that are uniquely experienced. They are based on time spent together with the person that died; the distinctive quality of the relationship with all its nuances; the place of the person in his circle of family, friends, colleagues and his or her particular culture. It is my belief that this experience cannot be reduced to a list of symptoms, and studied as such. In fact, to generalise symptoms and experiences in this field is of limited value.

This study aims to bring a deeper understanding of the grief experience through the description of the case studies. The purpose of such a full and rich description of each individual’s experience can illuminate the complexity, intricacies, and multi-layered nature of the actual lived grieving experience. It is hoped that the nuanced complexity of this deeply human experience can be described without reduction, in terms of the individual’s own frame of reference, and will thus bring a deepening of comprehension for clinicians and people faced with grieving individuals. The goal with qualitative

research is not to generalise, but to bring a clearer understanding of the information-rich lived experience. “Qualitative studies usually lie along a continuum of theory application at one end and theory development at the other. In the latter case, the emphasis is placed on developing a theoretical perspective as it emerges from the phenomenon itself” (Kilbourn, 2006, p. 545). In this study I hope to contribute to a growing case study literature, but more so, emphasise that grief therapy isn’t just about ‘getting over’ the symptoms, and raise the awareness for therapists that this work may indeed entail fruitful discussions about growth and discovering strengths the person did not previously know they possessed.

### **2.3.3 Narrative Research**

Narrative research, as the term implies, is research into the narratives or stories of people’s lives. Narrative inquiry makes use of texts from therapeutic conversations to journals, letters, interviews and family stories that document people’s life experiences. These stories become the object of study and units of analysis to understand the way people create meaning in their lives. Jean Clandinin and Michael Connelly’s book (2000) gives a beautiful and eloquently written description of this type of research as working in metaphorical three-dimensional narrative inquiry spaces – temporality on one dimension, the personal and social along another, and place along a third. This, the authors contend, brings complexity and depth. The researchers are never “disembodied recorders of somebody else’s experience” (p. 81) but are part of the experience. Therefore, the data or what the authors call ‘field texts’ are always acknowledged to be imbued with interpretation.

White (in Denborough, 2004) makes it clear that, unlike conventional research, the process of Narrative research, or what he prefers to term ‘co-research’ does not claim to be objective, nor does it aspire to objectivity. The process and purpose is to generate knowledge about that which can influence in preferred ways a person’s relationship with the particular issue for which they have sought counselling.



Narrative research is a hybrid methodology drawing on many research disciplines, including anthropology, sociology, psychology, history, and literature (Chase, 2005). Like grounded theory, it is a qualitatively oriented research method, designed to explain meaning and story. Unlike grounded theory however, narrative research often focuses on the stories after they are gathered: “Narrative research involves retrospective meaning making” (Chase, 2005, p. 656).

Narrative research often presents information from a very small sample and gives voice to the participants’ meanings and interpretations. Whether oral or written, stories need a way in which they can be studied, honoured, and used for benefit (Chase, 2005). Similar to oral history, narrative research is interested in how the events of life impact upon the individuals who experience them. The meanings ascribed to the lived events are of interest, not just the event itself or the outcome.

Narrative research is not about the discovery of ‘findings’ (Epston, 2004) which assumes the objective observation of behaviour. In fact, David Epston talks of knowledge-in-the-making: “There is no wish at all to use the conceit of ‘completed knowledges’ that promise to have all the answers” (Epston, 1999, p. 149). Narrative research also differs from classical ethnography which is also interested in people’s stories. Ethnography has traditionally collected stories with a positivist orientation, believing objective observation gathers accurate information about people and cultures (Foley & Valenzuela, 2005). While there have been recent shifts in this thinking in what is being labelled ‘critical ethnography’ (Foley & Valenzuela, 2005; Holstein & Gubruim, 2005), there remains an interest in the subjective inner experiences and discourse of those observed in the ethnography field. Narrative research makes the role of the researcher in the process explicit. More than merely an observer of experience, the researcher becomes the co-generator of the outcome. According to David Epston (2004), unlike conventional research, the process of co-research does not claim to be objective, nor does it aspire to objectivity. The process itself is inextricably entwined with its purpose - to generate

knowledge that can influence in preferred ways a person's relationship with the particular issue for which they have sought counselling (p. 31).

## **2.4 Data Analysis**

### **2.4.1 Miller and Crabtree's 'Dance of Interpretation'**

"Interpretation is a complex and dynamic craft. With as much creative artistry as technical exactitude, and it requires an abundance of patient plodding, fortitude and discipline" (Crabtree & Miller, 1999, p. 128). Miller and Crabtree describe the dance of interpretation as one where the researcher has to be flexible and dynamically open to what the study requires of him or her, and as a good clinician makes sense of a client's story, a qualitative researcher makes sense of their data. Both, they note, have to be iterative and responsive. The two "dancers" are the "interpreters and the text" (p. 129). The audience for the researcher include other researchers or clinicians in the field, academic peers, family and even funding sources. This sentiment ties in beautifully with Social Constructivism of course, where a text or study, indeed a human life and most definitely a grief experience, are socially constructed and dynamically influenced.

Miller and Crabtree describe an interpretive process consisting of five phases that they continue to describe in eloquent language as a process through which one "iteratively spirals and shifts" (p. 130). The five phases are a) describing, b) organising, c) connecting, 4) corroborating/legitimizing, and 5) representing the account. Describing links the data collection to the phase of interpretation. The middle three steps are the actual analysis part of the larger interpretive process. The account phase stays linked to the analysis.

A strong emphasis is placed on iteration within the analysis phases – between data collection and data interpretation (in the describing phase); where organising and connecting and so on spiral back and forth many times, between analysis and account where the account or story often develops along with the analysis. Therefore, the

authors do not recommend that the researcher(s) wait until after the analysis is done to tell the story of the results. They make mention of a final iterative cycle, to my mind perhaps the most important - the “self-reflection loop” (p. 131) – the iterative cycle of reflexivity that the researcher goes through as he or she learns about themselves and the research topic. I can attest to the veracity of this personal process, as I’m sure many doctorate students would!

In short, the Dance of Interpretation’s steps entail the following:

Describing: A reflexive phase where the researcher asks questions about the research process and what has been learned, how earlier assumptions have changed and what methods are used to challenge thinking. Important questions are asked about the paradigm being used, the collection process and the proposed analytic approach that is consistent with it. A note of caution is mentioned to avoid switching from a constructivist paradigm back to a positivist paradigm half way through the research process.

Organising: Involves choosing an organising style which is a scheme for approaching and relating to the material one wishes to analyse. Three organising styles are proposed: template, editing and immersion/crystallisation. In this study, immersion/crystallisation is preferred which implies that as the researcher immerses him or herself in the field of research and engages with the material, such as in this study with both the pertinent literature and the in-depth immersion with the case studies, the material begins to crystallise for the qualitative researcher into meaningful units and analysable categories that could be connected and represented in an account later on. In this organising style that seems to be the most appropriate for an in-depth grief study, explicit categories or codes are not used although themes emerge and crystallise throughout the process. The interpreter “as an intuitive participant” serves as the “organizing system” (p. 135) and the phases of organising, connecting and corroborating/legitimizing are collapsed into an extended period of immersion in the data, out of which interpretations crystallise. In a sense, this seems to me to a large degree what happens in the process of psychological therapy too.

Connecting: Once the data is organised to some degree, making sense begins in earnest as connections are made as the researcher patiently and reflectively engages with the text or data. In this phase, themes or patterns are discovered, categories are linked, models are developed and sometimes even new theories developed.

Corroborating/Legitimizing: Miller and Crabtree note that this is similar to Heidegger's "uncovering" and the authors choose the word "corroborating" to mean the researcher explores, confirms and makes more certain as the data is reviewed again, re-affirming previous interpretations and confirming internal consistencies (p. 136).

Representing the Account: This is the final phase where the new understandings and interpretations are shared and account is given of the research that was done. How the account is given is open to wide possibilities, but it should be done in a way that is in line with the operating paradigm. So, for instance, if it is qualitative research, a researcher should avoid slipping back into positivists reporting. Constructivist's enquiry will honour the multiple voices in the narrative and in this study, will provide rich descriptions with clearly articulated clinical relevance because the psychological research is undertaken about a therapeutic model with clinical application to the experience of grief.

#### **2.4.2 Thematic Content Analysis**

As the name implies, "thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic" (Braun & Clarke, 2006, p. 79). Joffe and Yardley (in Marks & Yardley, 2004) differentiate between content and thematic analysis by noting that while content analysis gives a numerical description of features in a text, thematic analysis focusses more on the qualitative aspects of the material being analysed. Furthermore, it provides analysis of *meaning in context* "thus adding the advantages of the subtlety and complexity of a truly qualitative analysis" (p. 57).

A theme in thematic content analysis is a specific pattern in the data in which one is interested, such as growth through the process of bereavement. Themes are the patterns across data sets, such as across case studies, which are important to the description of a phenomenon such as bereavement. Joffe and Yardley note that existing theories drive the questions the researcher asks. Accordingly, the researcher looks for patterns in the data and divides up the data to yield greater clarity regarding the themes. The themes are then analysed and the nuances of the recurring themes are explored in depth. Daly, Kellehear, & Gliksman (1997) agree – the writer's point of view guide the discernment of themes. The themes that emerge become the categories of analysis. They note that the themes may be clustered to form overriding themes, or subthemes may be identified that support the main themes in the material. The authors further mention *semiotic analysis* that takes it further by analysing the material in more depth – for instance by asking 'what is not being mentioned here?'; 'why?' and 'is there any specific reason why not?'. This specific analysis can shed light on, for instance, cultural restrictions on what is or isn't the norm in grief practices, and how this would influence the client's grief experience and grief story being told. "Semiotic analysis is the art of literary and social theorists, and represents the opposite of methodological position of positivism." (p. 135).

Braun and Clarke (2006) note that thematic content analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data, as long as it is applied in a theoretically and methodologically sound way. Citing Attride-Stirling (2001) and Holloway and Todres (2003), Braun and Clarke note that in order for this to be the case, researchers need to make their (epistemological and other) assumptions explicit, be clear about what they are doing and why, and include the often-omitted 'how' they did their analysis in their reports. The writers emphasise the importance of recognising the researcher's active role who identifies themes or patterns in the material, selects which are of interest, and reports them in the report. For Braun and Clarke, it is important to acknowledge that the researcher does not make it seem as if the themes merely emerged, but acknowledges that he or she actively selects and highlights themes. This is not a problem as long as the

researcher recognises this process, and therefore is cognisant of how the theoretical framework and methods match what the researcher wants to know. “Any theoretical framework carries with it a number of assumptions about the nature of the data, what they represent in terms of the ‘the world’, ‘reality’, and so forth. A good thematic analysis will make this transparent” (p. 81).

Braun and Clarke’s (2006) seminal article advises the researcher to distinguish whether they would prefer to provide a rich description of the data set, or rather a detailed account of one particular theme or group of themes. In this study a full and rich description of the whole grief and indeed life experience at that particular junction in the life of the bereaved will be investigated, that will of necessity mean that for the sake of succinctness some depth and complexity will be lost, but it is hoped a rich and accurate description will give a sense of significant and central themes.

A further distinction in data analysis is noted by Braun and Clarke (2006) – in *An inductive as opposed to in a deductive-theoretical way*. In this study the preference is for an inductive thematic analysis that is data- rather than purely theory driven, as far as possible not trying to fit the themes too strongly into the researcher’s preconceptions, bearing in mind that “data are not coded in an epistemological vacuum” (p. 84).

Similarly, themes could be identified at two levels: at a *semantic or explicit level*, or at a *latent or interpretative level*. Again, the preference is for depth of analysis and in this study to allow underlying ideas and assumptions on the latent level to emerge, that may be informing the semantic content of the data. As an example, cultural expectations and conventions may not be explicitly mentioned by the bereaved person, but may silently be informing how, when and for how long a person feels they are supposed to grieve. The authors mention that analysis from this tradition tends to come from a constructionist paradigm.

A handy contribution to qualitative research is provided by Braun and Clarke (2006) in what they call 'a step-by-step guide' to doing thematic analysis. The following table from their article on page 87 provides a good summary:

<b>Phase</b>	<b>Description of the process</b>
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

The authors remind us that theme analysis is not a linear process of simply moving from one phase to the next. Rather, it is a recursive process with back and forth movement throughout the phases.

## 2.5 Trustworthiness

According to an article by Andrew Shenton (2004), the aim with qualitative research is that a true picture of the phenomenon under scrutiny should be presented, and that the findings should emerge from the data and not the researcher's own predispositions.

My aim would therefore be to make sure that:

- Credibility will be established by the adoption of well-established research methods - one may define this study as a *descriptive multiple case study method*. This method also provides for other data sources such as letters written to deceased loved ones, journals kept and emailed correspondence as part of the study, that will enrich and be used in conjunction with information from therapeutic conversations with clients.
- The research field is clearly delineated and adhered to.
- The process notes will be carefully kept and honestly reported.
- The data will be analysed appropriately to the study at hand.
- Information will be triangulated. That means various data collection strategies combines information such as the therapist's observation of the processes the person goes through and experiences during therapy, coupled with self-stated outcomes by the person during the interview. The use of both these sources of information in concert may compensate for subjective data gathering only during the course of therapy.
- "Thick description of the phenomenon under scrutiny" (Shenton, 2004, p. 69) will be used, i.e. glib assumptions based on flimsy amounts of evidence will be avoided.
- Participants will be encouraged to be frank and honest and they will be assured that there are no right or wrong answers. They will also be informed that their experiences are only described with their consent, and that they may withdraw from the study if they so wish.



- The qualifications and experience of myself as both therapist and researcher come to bear on a study like this, and I will aim to give both the highest quality of care possible, as well as act ethically, professionally and compassionately throughout.
- Findings from the study will be related to an existing body of knowledge about the subjects involved, as Silverman (2001) suggests.
- Guba (1981) recommends a full description of all the contextual factors impacting on the inquiry to further strengthen trustworthiness.
- The boundaries of the study will be conveyed such as the number of participants in the study, the data collection methods used, the time periods over which the data was collected, and where the research was based. (Shenton, 2004)

## **2.6 Reliability and Dependability**

Golafshani (2003, p. 601) says “If we see the idea of testing as a way of information elicitation then the most important test of any qualitative study is its quality. A good qualitative study can help us understand a situation that would otherwise be enigmatic or confusing”. He argues that quality in qualitative studies implies the purpose of ‘generating understanding’ rather than explaining as one would find in a quantitative study. He goes as far as to say “The difference in purposes of evaluating the quality of studies in quantitative and quantitative research is one of the reasons that the concept of reliability is irrelevant in qualitative research.” (p. 601)

By the nature of a qualitative study, in the same way that therapy would be a unique experience with each person, the descriptions are of specific individuals in a specific context, historical moment and of their unique experience of an event, albeit a universally experienced event. The results can thus not simply be extrapolated to all grieving persons nor will the results and observations be replicable or repeatable. In fact, the aim of qualitative studies is to provide rich individual descriptions rather than

generalise. Yet the experience of grief counselling is obviously replicated all over the world on a regular basis.

The dependability of this study will thus lie with the repeatability of the methods (both therapeutic and research methods) if not necessarily with the results. The processes within the study will therefore be reported on in detail, so that a future researcher may conceivably be able to repeat the study. The research design, operational data gathering as well as the reflective evaluating of the effectiveness of Narrative Therapy as bereavement therapy will be well documented. And throughout the emphasis will be on quality – both in the therapeutic as well as the process of data gathering and description.

## **2.7 Ethical Considerations**

Dawn Darlaston-Jones (2007) emphasises that working ethically requires more than following a code of conduct - it requires that we examine our motives and scrutinise our actions and our research processes for foreseeable and perhaps unforeseeable consequences that might affect our participants or have even broader repercussions to society. She describes the need for sensitivity in psychological research, particularly when your subjects are distressed such as by grief, and the need for the people you study to feel safe.

Daly, Kellehear and Gliksman (1997) put it simply, beside confidentiality and informed consent, “We must always consider the potential of results to cause unintentional harm.” (p. 137)

In this study, the following procedures are adhered to:

- Informed Consent to take part in the study is of utmost importance and will be obtained in written format. The purpose of the study will be explained and what information will be used and that participation is voluntary.

- Confidentiality and anonymity will be ensured, and when case studies are described, pseudonyms will be used and certain non-essential identifying particulars will be changed, so that if somebody they knew were to read their story, they would not be clearly identifiable.
- Clients will be assured of the right to withdraw from the study, with the option of continuing normally with therapy.
- Therapy will be guided by the needs of the client, and not by the aims of the study. The needs of the person in distress will always be paramount. All effort will be made to not let any harm come to the participating client because of the study or therapy.
- Contra-indications for therapy will be in the presence of psychosis or serious chemical dependency.
- The practitioner will at all times aim to provide the highest standards of care and will bring her experience as well as relevant training to bear in the therapeutic situation.

## Chapter 3

### Grief and Grief Counselling as Social Constructs

*And I believe that love is stronger than death.*

**Robert Fulghum**

#### 3.1 On Death and Dying

We live in the sure knowledge of our death, and yet most of us live as if it will never happen to us, or our loved ones. We spend our days surviving, collecting, building, and when a thought of our eventual demise comes up, most of us squash it immediately, believing that ignorance is bliss. We spend a great deal of our time focussing on our physical wellbeing. Yet, we cannot avoid this natural aspect of life. Sooner or later, we all have to deal with it, whether it is in facing our own mortality, or having to deal with the loss of a loved one.

Death is a ubiquitous yet frightening experience, one which fills most of us with dread. Death is the ever-present reality in our lives. Yet fear of change, fear of the unknown, fear of suffering, fear of end, and fear of loss of identity are all very common human emotions.

Before about 1930, most people died in their own homes, surrounded by family, and comforted by clergy, neighbours, and doctors making house calls. By the mid-20th century, half of all Americans died in a hospital (Ariès, 1974). With the advent of the 21<sup>st</sup> century, only 20 to 25% of people in developed countries died in the community. This move away from dying at home, towards dying in a professionalised medical environment, has been termed the "Invisible Death" by Nuland (1994).

Al Whitney and André Smith in *Exploring Death and Dying through Discourse* (2010, p. 68-69) believe that “As the process of death and dying becomes increasingly defined as a technical problem, a medical discourse prevails in which death is disguised, demeaned, and ignored.” They note that the subject of death inevitably raises existential questions, and ponder whether our society fears death itself, the process of dying, or the clinical, impersonal death so many experience in hospitals surrounded by clinicians who don’t know who we are. Kauffman (2001) distinguishes between a ‘good death’ or ‘death with dignity’ which is conceptualised in relation to personal control in dying on the one hand, versus the pain, suffering, loneliness, and lack of autonomy brought about by the use of advanced technology in the hospital setting. Taking death into hospitals has in a sense removed it from the natural part of life people saw it as, and made it perhaps even more mysterious, and frightful, for post-modern humans.

*Let children walk with Nature, let them see the beautiful blendings and communions of death and life, their joyous inseparable unity, as taught in woods and meadows, plains and mountains and streams of our blessed star, and they will learn that death is stingless indeed, and as beautiful as life.*

- John Muir (2013, p.13)

### **3.2 Grieving and Bereavement**

The Old English term *reave* or *bereafiani* has become our modern word ‘bereavement’. The archaic definition included ‘to be robbed’ or ‘deprived of something valuable’ (Chambers Dictionary, 1995). In contemporary society *bereavement* most commonly refers to the process following the death of a significant person. Bereavement can be expressed in culturally various acts of *mourning*, for example; funeral ceremonies, or ritualised withdrawal from public activities. ‘*Grieving*’ refers to the psychological component of bereavement, the feelings evoked by a significant loss, especially the suffering entailed when a loved person dies (Madison, 2005). A loss is what happens (the

event, or perceived event), grief is the emotional response, and bereavement is the process after the loss, hopefully including, or leading to, healing.

The relationship between the bereaved and the deceased loved one informs the individual grieving experience. There is an enormous difference between losing a cherished husband of many years, or dealing with the death of an abusive one. The closeness of the emotional ties, the quality of the relationship, the degree to which the person depended on the deceased both practically and emotionally, all radically influences the grieving experience. As Hedtke (2002, p. 10) in her article *Reconstructing the language of death and grief* so succinctly put it: "The significance of a person's life continues even if the person is not around to remind people."

In addition, the way that the person died, for instance whether the death was due to a prolonged illness when there was time to say goodbye and make amends, or due to a sudden, violent death dramatically alters the gamut of emotions that the bereaved person experiences. Furthermore, the personality of the bereaved person will influence whether the person will choose to rely on others for support, or make grieving a solitary affair, choose to wail and lament, or choose to mourn in quiet solitude. There is no recipe, no specified time limit, no one-size fits all.

Grief and bereavement is not an uncluttered bundle of emotions, which one works through, and then puts behind one. In fact, grief continues and it is not unusual to see an old person cry about a lost friend when she was young, or a mother cry about her child who died decades ago. One does not find neat and tidy 'closure'. Most find that their daily lives are affected on every level, even though they continue with ordinary daily activities. The deceased loved one is at the same time absent, yet acutely present all the time. With time, the intensity of the emotions lessens, and the person gets used to a new normal. Eventually most will learn to live with the loss. They may revisit that loss at different points in their lives and experience grief again, and have times of normality,

joys and the ups and downs of life in between these times. Often a person grows through the process. The phrase 'continuing bonds' used in postmodern grief theories, also in Narrative Therapy, is a contribution to a new language that reflects a more compassionate understanding of this process.

### 3.2.1 Grief Reactions

Reactions to a loss can be physical and psychological. It is not uncommon to experience periods of intense distress and feeling such as (but not limited to) the following: longing, crying, dreaming of your loved one, anger, denial, sadness, despair, insomnia, fatigue, guilt, loss of interest, confusion and disorganization, disbelief, inability to concentrate, preoccupation with thoughts of your loved one, fleeting hallucinatory experiences, meaninglessness, withdrawal, avoidance, over-reacting, numbness, relief, sadness, yearning, fear, shame, loneliness, helplessness, hopelessness, emptiness, loss of appetite, weight gain.

Schwiebert (2003) lists grief reactions that are common especially during the early stages of loss, including:

#### *Physical Symptoms:*

- Hyperactive or under active.
- Feelings of unreality.
- Physical distress such as chest pains, abdominal pains, headaches, nausea.
- Change in appetite.
- Weight change.
- Fatigue.
- Sleeping problems.
- Restlessness.
- Crying and sighing.
- Shortness of breath.
- Tightness in the throat.
- Loss of appetite or over-eating.
- Sleeplessness.
- Dry mouth and skin (possibly caused by dehydration from crying).
- Extreme tiredness.
- Increased sensitivity to loud noises.

- Pain that may mimic the way the loved one died, such as in the chest area.

*Emotional Reactions:*

- Shock and disbelief.
- Sorrow.
- Guilt ('if only's' are common).
- Loneliness and a sense that no one really cares about you or understands what it's like.
- Loss of a sense of meaning in life.
- Relief (especially when the deceased suffered before death, or in a sudden death, where there was no suffering).
- Anger.
- Depression.
- Numbness.
- Fear.
- Irritability.
- Longing.
- Anxiety.

*Cognitive Experiences:*

- Frequent thoughts about the one who died.
- Difficulty maintaining concentration.
- Forgetfulness.
- Confusion.
- A sense of unreality.
- Shock and numbness.
- Feeling detached from others.
- Lack of motivation.
- Hallucinations, sensing the loved one's presence.
- Slowed thinking.

*Behavioural Reactions:*

- Searching for the deceased.
- Wandering aimlessly.
- Trying not to talk about loss in order to help others feel comfortable.
- Needing to retell the story of the loved one's death.
- Apathy.
- Dependence.
- Withdrawal.



*Spiritually – Philosophically:*

- Why did God let him die? Why him/her? Why me?
- Why is God punishing me? Life is unfair!
- What did I do wrong to deserve this?
- What is the meaning of life? What is the point to it all?

(Schwiebert, 2003).

### **3.2.2 Different Types of Grief**

#### **3.2.2.1 Normal or Uncomplicated grief**

When it comes to a person's emotions with the passing of a loved one, there is no typical or average. Grief is always individually experienced and is an extraordinary event in a person's life experience. There are no timelines and grief experiences generally vary from one individual to another. While uncomplicated grief may be extremely painful, disruptive and consuming, Zisook and Shear (2009) point out that it is usually tolerable and self-limited and does not require formal treatment. 'Normal Grief' is marked by movement towards acceptance of the loss and a gradual alleviation of the symptoms, as well as the ability to continue to engage in basic daily activities. (Haley, 2013.) Zisook and Shear (2009) point out that "complicated grief and grief-related major depression can be persistent and gravely disabling, can dramatically interfere with function and quality of life, and may even be life threatening in the absence of treatment" (p. 67).

When Engel raised the question 'Is grief a disease?' in 1961 as the title of his now classic article on the subject (cited in Zisook and Shear, 2009), he argued convincingly that grief shares many characteristics of physical diseases, such as a known aetiology (in this case, death of a loved one), distress, a relatively predictable symptomatology and course and functional impairment. And while healing usually occurs, it is not always complete. In some bereaved individuals with pre-existing vulnerabilities, for example, the intense pain and distress festers, can go on interminably (as 'complicated grief'), and the loss may provoke psychological and psychiatric complications, such as major depression.

The suffering and agony experienced after the loss of a loved one can be severe. Colin Murray Parkes (in Stroebe, Stroebe & Schut, 2001) examined the case records of 3245 adult psychiatric patients admitted to two psychiatric units in London. He found that the incidence of death of a spouse during the six months preceding the psychiatric illness was six times greater than would have been expected from the rates of bereavement obtainable from mortality figures among people of the same age.

Grief is varied and fluid and differs considerably in intensity and length among cultural groups and from person to person. It is often hard to predict how a person will cope with their loss, why they experience varying degrees and types of distress at different times, and how or when they adjust to a life without their loved one over time. The bereaved person's personality, the relationship with the loved one, the culture they find themselves in, even their gender, will influence the grieving experience.

The terms *bereavement* and *grief* are used interchangeably in the literature to refer to either the state of having lost someone to death, or the response to such a loss. Zisook and Shear (2009) suggest that the term bereavement be used to refer to the fact of the loss; the term grief should then be used to describe the emotional, cognitive, functional and behavioural responses to the death. Also, grief is often used more broadly to refer to the response to other kinds of loss: people also grieve the loss of their youth, of opportunities, and of functional abilities. Mourning is also sometimes used interchangeably with bereavement and grief, usually referring more specifically to the behavioural manifestations of grief, which are influenced by social and cultural rituals, such as funerals, visitations, or other customs.

How long grief lasts and how intensely it is experienced are highly variable, not only in the same individual over time or after different losses, but also in different people dealing with ostensibly similar losses. The intensity and duration is determined by multiple forces, including, among others the individual's pre-existing personality,

attachment style, genetic makeup and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; the nature of the relationship (e.g., interdependent vs. distant, loving vs. ambivalent); the relation (parent vs. child vs. spouse vs. sibling vs. friend, etc.); type of loss (sudden and unanticipated vs. gradual and anticipated, or natural causes vs. suicide, accident or homicide) (Bonanno & Kaltman, 2001).

Zisook and Shear (2009) point out that grief is not a state, but rather a process. They also emphasise, like Klopper (2009) that the grief process typically proceeds in fits and starts, with attention oscillating to and from the painful reality of the death. Furthermore, the spectrum of emotional, cognitive, social and behavioural disruptions of grief is broad, ranging from barely noticeable alterations to profound anguish and dysfunction. "At first, these acute feelings of anguish and despair may seem omnipresent, but soon they evolve into waves or bursts, initially unprovoked, and later brought on by specific reminders of the deceased. Healthy, generally adaptive people likely have not experienced such an emotional roller coaster, and typically find the intense, uncontrollable emotionality of acute grief disconcerting or even shameful or frightening." (Zisook and Shear (2009, p. 69).

Shear and Mulhare (2008) distinguish between two periods of grief: the first is the *acute grief* that occurs in the early aftermath of a death. This can be intensely painful and is often characterised by behaviours and emotions that would be considered unusual in normal everyday life. These include intense sadness and crying, other unfamiliar dysphoric emotions, preoccupation with thoughts and memories of the deceased person, disturbed neuro-vegetative functions, difficulty concentrating, and relative disinterest in other people and in activities of daily life (apart from their role in mourning the deceased). This form of grief is distinguished from a later form of grief, *integrated or abiding grief*, in which the deceased is easily called to mind, often with associated sadness and longing. During the transition from acute to integrated grief, usually commencing within the first few months of the death, the wounds begin to heal and the

bereaved person finds his or her way back to a fulfilling life. The reality and meaning of the death are assimilated and the bereaved are able to engage once again in pleasurable and satisfying relationships and activities. Yet, though the grief has been integrated, they do not forget the people they lost, relinquish their sadness nor do they stop missing their loved ones. The loss becomes integrated into autobiographical memory and the thoughts and memories of the deceased are no longer preoccupying or disabling. Unlike acute grief, integrated grief does not persistently preoccupy the mind or disrupt other activities. There may however be periods when the acute grief reawakens, for instance around the time of significant events, such as holidays, birthdays, anniversaries, another loss, or a particularly stressful time. It would be safe to say, based on these thoughts, that for most people grief is never fully completed and one may still find sadness and tears welling up decades after the loss of a loved one, even as one goes about life normally.

Some authors (Bonanno, Wortman & Nesse 2004; Zisook & Shear 2009) have commented that, although the predominant emotion might be pain in times of grief, in an uncomplicated grief process, painful experiences are intermingled with positive feelings, such as relief, joy, peace, and happiness that emerge after the loss of an important person. Frequently, these positive feelings elicit negative emotions of disloyalty and guilt in the bereaved. Of note, at least one investigator has found that positive feelings at 6 months following a death are a sign of resilience and associated with good long-term outcomes (Bonanno, Wortman & Nesse 2004).

### **3.2.2.2 Anticipatory Grief**

The notion of grief that begins in anticipation of loss has been coined by Erich Lindemann. He used this phrase for the first time in his 1944 paper *Symptomatology and Management of Acute Grief* and it has become part of the nomenclature of grief psychology. He is cited in William Worden (1991): "The term anticipatory grief was coined some years ago by Lindemann (1944) to refer to the absence of overt manifestations of grief at the actual time of death in survivors who had already

experienced the phases of normal grief and who had freed themselves from their emotional ties with the deceased.” (p. 108.)

The term is more often understood as the reaction to a death you were able to anticipate such as when an individual dies from a long-term illness. As soon as you accept and understand someone you love is going to die, you begin grieving. Haley (2013) notes that grief that takes place preceding a loss can be confusing as a person may feel conflicted or guilty for experiencing grief reactions about someone who is still here. Similar emotions to uncomplicated or ‘normal’ grief may be experienced such as anger, loss of emotional control, and helplessness. A person may also feel grief over the loss of things other than the individual, such as loss of hopes and dreams for the future and the loss associated with changing roles and family structures. Many people describe an oscillation of feelings from sadness to hope, despair, and gratitude for interactions with a dying loved one that has suddenly become very precious.

Haley (2013) observes that Anticipatory Grief can allow those who love the individual to slowly and gradually prepare for and absorb the reality of the loss. Furthermore, it allows for the possibility of meaningful time spent with the individual leading to an increased sense of closure and peace.

### **3.2.2.3 Complicated Grief**

Zisook et al. (2010, p. 1097) give a good description of what they see as the syndrome of *Complicated Grief*: it “is characterized by continued severe separation distress and by the dysfunctional thoughts, feelings or behaviors related to the loss that complicate the grief process. Symptoms of separation distress include intense yearning, a persistent, strong desire to be with the deceased; and by the inability or refusal to accept the death, preoccupation with thoughts or images of the person who died, and compulsive proximity seeking (e.g. keeping reminders of the person who died close by). Complicating features include ruminating about circumstances or consequences of the

loss, unrelenting anger or bitterness, intense physical or emotional reactivity to reminders, avoidance of reminders, social estrangement, feeling lost and unfocused, and believing that ongoing life is now empty and meaningless and that joy is no longer possible. We draw attention to the fact that all patients with Complicated Grief should be carefully assessed for suicidality. Suicidal thoughts are very common in Complicated Grief and are of concern as suicide attempts also occur. Suicidal urges are usually related to hopes of finding or joining the deceased loved one or feeling that life without the deceased person is unbearable.”

Haley (2013) concurs that Complicated Grief describe grief reactions and feelings of loss that are debilitating, long lasting, and/or impair the bereaved person’s ability to engage in daily activities. She believes that other types of grief such as ‘Chronic Grief’, ‘Delayed Grief’, and ‘Distorted Grief’ all fall under the blanket of ‘Complicated Grief’.

Research done by Simon et al. (2007) found that Complicated Grief occurs in about 10% of bereaved individuals, and usually among individuals with a close, identity-defining relationship to the person who died. The risk may be increased among those with a history of mood or anxiety disorder, and possibly following a violent death or suicide. Because of the on-going and often severe psychological distress and risk of suicide, Zisook et al. (2010) plead for an inclusion of Complicated Grief in the DSM. Zisook et al. (2010) note that “Complicated Grief Therapy utilizes a dual focus on coming to terms with the loss and restoring the capacity for pleasure and satisfaction in on-going life” (p. 1098).

#### **3.2.2.4 Chronic Grief / Prolonged Grief Disorder**

For some bereaved persons, their strong grief reactions do not subside or lessen, but remain either the same or increase in intensity over a long period of time. This means continually experiencing extreme distress over the loss with no progress towards feeling better or improving functioning. Jordan and Litz (2014) describe on-going intense

longing for the deceased, and the thwarting of loss-processing and functional restoration tasks that ordinarily lead to resolution of grief. Furthermore, the bereaved person avoids fully facing the reality of the loss and adopting new roles, even sometimes showing an aversion to seeking support. The bereaved person then spends much time contemplating the death, longing for reunion, and in general is unable to adjust to life without the individual.

#### **3.2.2.5 Delayed Grief**

Bonnano and colleagues published a study in 2002 noting that about 4% of people showed delayed grief eighteen months after the passing of a loved one (cited in Worden, 2009). Worden describes delayed grief as inhibited, postponed or suppressed grief reactions that occur either when the emotional loss is too overwhelming to face (also when there are multiple losses suffered, for instance), or if there is a lack of support at the time of loss. Worden notes that it does not mean that grief was totally absent at the time of the loss, but that it was not adequately processed at the time, for instance because of dealing with other urgent matters requiring attention. The grief and sorrow then resurfaces later in the form of deep sorrow and excessive crying in the face of a lesser loss.

#### **3.2.2.6 Cumulative Grief**

Sometimes a person may not have had time to adjust to a loss, before they suffer another. This is also referred to as 'bereavement overload' or 'grief overload' (Haley, 2013). A person may feel that very little opportunity or time was given to adequately process and come to terms with the first loss before it was compounded by, and distracted by another. At this stage grief can become complicated and the bereaved person may be at greater risk of developing depression or act with avoidance.

### **3.2.2.7 Exaggerated Grief**

This is an overwhelming intensification of normal grief reactions that may worsen over time, characterised by extreme and excessive grief reactions which may include nightmares, self-destructive behaviours, drug abuse, thoughts of suicide, abnormal fears, and the development or emergence of psychiatric disorders. (Haley, 2013). Worden describes the development of clinical depression, general anxiety disorder, phobias (including agoraphobia), alcoholism and other substance abuse that show grief symptoms that have become so extreme as to be “excessive and disabling” (Worden, 2009, p. 142).

### **3.2.2.8 Secondary Loss**

When a loved one dies, the loss of the person is not the only one felt. Typically, the loss impacts many areas of a person’s life, creating multiple losses stemming from the primary loss. Haley (2013) points out therefore that our grief is not solely the grief of losing the person who died, our grief is also the pain of the other losses caused as a result of this death. Sister Mary Agnes Sermersheim (n.d.) wrote a beautiful article in which she lists some of the secondary losses a person also has to adapt to such as the loss of identity; a certain life role - such as a parent or a spouse; the loss of known family structure; the loss of the familiar way of relating to family and friends who may be responding to one with sympathy or avoidance; the loss of a familiar future and fearing planning the future in the light of the fact that losses can and do occur, as well as future dreams such as ‘spending the rest of my life with the person I love’ or ‘seeing my child grow up’ or ‘having my parents be grandparents’; the loss of one’s own health – the physical problems resulting from the emotional stress and strain of grief work such as nausea, fatigue, migraine headaches, muscle knots, etc. and in losing the loved one, also the loss of sharing with what may have been your best friend and confidant who could listen to the little things and the big events of day-to-day living, or to share in the growing-up years of a child, or the retirement years (Sermersheim, n.d.).



### **3.2.2.9 Masked Grief**

A person may suffer “symptoms and behavior that cause them difficulty but they do not recognize that these symptoms and behaviors are related to the loss.” (Worden, 2009. p. 144). Examples may be the development of physical symptoms without a somatic cause, such as chest pain when their loved one died from a heart attack, or maladaptive or even delinquent behaviour that follows a loss. Worden remarks that once the therapist helps the bereaved person make the connection between their symptoms and their grief, resolution and relief from symptoms may occur.

### **3.2.2.10 Disenfranchised Grief**

Foucault (in Whitney and Smith, 2010) uses the term archaeology to describe the study of statements throughout history, specifically, what is included and excluded, and the ways in which these statements are used to structure and legitimize certain types of knowledge. Foucault uses genealogy to describe the search for connections between ideas (that affect practice) and institutions. In all cultures, there are written and unwritten rules about who should be grieved, how and how much.

A stigmatising death, such as that by suicide or as a result of autoerotic asphyxiation, can disenfranchise the griever (Doka, 2002) and complicate the bereavement experience. Haley (2013) elaborates that Disenfranchised Grief occurs when the bereaved person’s culture, society, or support group make them feel their loss and or grief is invalidated and insignificant. She mentions that this can occur when the death is stigmatised (for instance with suicide, overdose, HIV/AIDS, drunk driving); when the relationship is seen as insignificant (for instance the loss is of an ex-spouse, co-worker, miscarriage or pet); the relationship is stigmatised by society (e.g. same-sex partner, gang member, partner from an extramarital affair); or the loss is not a death (the loss is of a person with dementia, traumatic brain injury, or affected by mental illness or substance abuse). Hall (2011) adds that Disenfranchised Grief also occurs when the griever is being excluded

(such as a child), or indicates the way the individual expresses their grief, particularly with regard to the level of emotional distress which is publicly displayed.

Hall (2011) elaborates that Disenfranchised Grief is the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned or socially supported. He points out that the concept recognises that societies have sets of norms – in effect, ‘grieving rules’ – that attempt to specify who, when, where, how, how long and for whom people should grieve.

#### **3.2.2.11 Traumatic Grief**

Sometimes a bereaved person suffers from exposure to traumatic distress as a result of experiencing their loved one dying in a way that was to them frightening, horrifying, unexpected, violent or traumatic. This means that they struggle to come to terms not only with normal grief responses but also with the distress of the trauma (Haley, 2013). Tedeschi and Calhoun (2004) point out that the trauma can indeed be experienced so intensely, that some of the classic symptoms of post-traumatic stress may be displayed such as avoidance, numbing, flashbacks, hyper vigilance, and so on. Tedeschi and Calhoun therefore point out that those in helping professions should be familiar with this possibility and also with trauma therapy approaches for those whose grief also includes trauma elements.

#### **3.2.2.12 Collective Grief**

Grief felt by a collective group such as a community, society, village, or nation as a result of an event such as a war, natural disaster, terrorist attack, death of a public figure, or any other event leading to mass casualties or national tragedy, is called Collective Grief. Most of us can remember the outpouring on social media when Robin Williams died in December 2014, when Madiba died in in December 2013, or how we felt when Princess Diana died in 1997. An example of how collective grief can move people to action is

when 30 000 people attended a Jerusalem funeral of a US-born soldier Max Steinberg in July 2014. People feel a kinship with the person who died, as if they really knew him or her, and genuinely feel sad at the loss, if only fleetingly. Collective grief can also happen on perhaps a much deeper level in the shared sorrow following calamities such as the tsunami in Japan in March 2011 that killed almost 19 000 people.

### **3.2.2.13 Absent Grief**

This is when the bereaved shows absolutely no signs of grief and acts as though nothing has happened. This is characterised by complete shock or denial, especially in the face of a sudden loss. Haley (2013) notes that what seems to be the absence of grief becomes concerning when it goes on for an extended period of time. She points out that one has to account for differences in how we grieve and it's important to note that just because you can't tell someone is grieving doesn't mean they aren't. She further describes *Inhibited Grief* which is when an individual shows no outward signs of grief for an extended period of time, and *Abbreviated Grief* when someone might have a short-lived grief response because there was little attachment to the deceased, or the individual is able to accept and integrate the loss quickly due to Anticipatory Grief. Sometimes grief is abbreviated because the bereaved person might fill the role of the loved one with a 'replacement', such a new spouse. Clearly, this is likely to be a desire to escape the pain from the loss which denies the acknowledgement of the deep pain and loss that are underneath.

*From my perspective, the grief reaction is so fluid and individual that it is best to view the different expressions of grief compassionately rather than assume a stance that all bereaved persons should grieve the same way and for the same length of time. There really is no right or wrong way to grieve. Some people are outwardly expressive of grief, others are private. Some people want a lot of support and comfort while others need to grieve alone. Each person's sadness and redefining life after a significant loss is different and grief takes as long as it takes, there are no time limits on how long one should or shouldn't grieve. The tears and sorrow typically come in waves - one day a person may*

*feel fine and happy, and the next day overwhelmed by sadness and frustration at their loss. Eventually the waves of sadness get further apart and less intense over time and the wound becomes a scar that only hurts at times. When grief becomes complicated, has elements of post-traumatic stress, becomes overwhelmingly intense or distorted, or just too heavy to bear, it is best to find psychological help.*

### **3.2.2.14 Men and Women Grieve Differently**

It seems obvious that personality differences and the relationship with the deceased will influence a bereaved person's experience of grief. Breen (2006) cites research (e.g. McKissock & McKissock, 1991; Stroebe, Stroebe & Schut, 2001) that indicates that individual factors impact on the experience of grief such as one's age, cognitive style, coping strategies, gender, spirituality/religiosity, previous life history, and concurrent crises such as financial and relationship stressors.

Interestingly, various authors also point to gender differences in grieving: Schuchter and Zisook (1993) noted that research indicates that it is not unusual for men to have greater difficulty expressing emotion following spousal loss, and for men to enter into romantic relationships more rapidly after the death, and to demonstrate more significant struggles accepting the loss. Allen and Hayslip, (2000) observe that women typically report greater emotional distress following the death of a spouse and that they more readily admit to feeling helpless. Women also express more significant changes in identity and social role. Some authors such as Stroebe and Schut note that widowers are thought to be more likely than widows to feel distressed and depressed, to develop mental and physical illnesses, and to die within a short period after their spouse's death (M. Stroebe, 1998; M. Stroebe, Stroebe, & Schut, 2001). M. Stroebe (1998) suggests that the reasons for these findings include men's lower levels of social support outside the marriage, men in general seeking less social and emotional support than women, and the loss of their only confidante in their wife. Breen (2006) also observes that sex-role conditioning means that the ways of grieving, such as the open expression of emotion, may be incompatible with society's expectations of men. Martin & Doka (2000) differentiate between

'masculine grievers' (whether men or women) who are more likely to express anger and/or guilt and problem solve, and 'feminine grievers' who are more likely to express emotions such as sadness.

Wing, Burge-Callaway, Clance and Armistead (2001) call the different ways that men and women grieve incongruent grieving and point out that in marriage this may present difficulties for the couple. Citing various studies of parents following the death of an infant, they note that women and men report consistent differences in their experience of grief, and that, "although much individual variability is evident, women generally appear to experience most grief reactions with greater intensity and for a longer duration than men." (p. 61). These differences often lead to misunderstandings and conflicts between bereaved mothers and fathers and contribute to further pain and isolation.

### **3.3 Grief and Mourning as Social Constructs**

From a postmodern perspective, thoughts and meaning are created by humans in a social context and within a specific culture. From that perspective, grief and mourning are no different and will be socially informed and culturally shaped in the discourse and interaction between people.

In the constructivist model the purpose of grief is the construction of durable biographies—individual and social narratives—of the dead person and of the survivors that enable the living to integrate the dead into their lives, says Dennis Klass (1996). At the biological level, he notes, it might seem that grief is universal. In every culture people cry or seem sad after a death that is significant to them. Perhaps even animals grieve - primates and birds display behaviours that seem similar to humans' in response to death and separation. And yet, Klass explains, the concept of grief is an artefact of modernity: grief as a real subjective state grows from a culture that prizes and cultivates individual experience. There is no equivalent to the term *grief* in some other languages; indeed, in

some cultures, as in Japan, the concept of emotions that are only in the individual seems foreign. For the Japanese, individual identity is a function of social harmony and emotions are part of family or community membership, sensed among the members.

Klass emphasises that grief and mourning do not just happen inside a person - they happen in the interactions between people. In the constructivist model, the process by which people make sense of their world is social interaction. And so, when something important happens in individuals' lives, they do not just think about it; they talk about it with others. In most cultures over human history, myth and ritual provide the intersubjective space in which one can construct the meaning of the deceased's life, death, and influence over the survivors' lives (Klass, 1996). Rosenblatt (2001) concurs in his description of the development of concepts such as grief in society and he emphasises that it is very much a culturally constructed concept.

### **3.3.1 A Postmodern View of Mourning**

Walter (2007) explains that the terms modernity and postmodernity refer to social structure, while modernism and postmodernism refer to culture. He goes on to say that *modernity* fragments social relations and isolates the mourner who in daily life is surrounded by non-mourners. Modern societies are characterised by urbanisation and geographical mobility, leading to more complex and fragmented social circles. The modern individual is therefore detached from tradition, place, and kinship. Two responses to this are the private grief experienced in countries such as England which affirms individuality and the nuclear family, and social mourning in countries such as Japan which affirms the diverse networks of urban modernity. Walter makes the observation that *modernism* affirms faith in progress, in the future, in science, in expertise, and in the young, reflected in twentieth century grief psychology with its emphasis on leaving the dead behind and therapy to help malfunctioning individuals adjust.

On the other hand, *postmodernity* entails new forms of social relationships. Mourners may join groups in which they form communities with others who never knew the deceased, but who have suffered the same kind of loss and who may have first-hand experience, which may be valued over expert knowledge. Virtual relationships are also formed, e.g. mourning for dead celebrities and murdered children known only through the media. “*Postmodernism* deconstructs science and other meta-narratives, and celebrates diversity, tradition and heritage, reflected in theories that emphasise continuing bonds with the dead and the diverse ways people grieve.” (Walter, 2007, p. 123). Further on (p. 133) Walter discusses postmodernism that deconstructs the meta-narratives not only of traditional religion, but also of modernity. He explains that there is a loss of faith in, or at least ambivalence about, science, progress and the future; there is nostalgia for tradition and heritage; and that diversity is celebrated. No longer can a priest or scientific expert tell us how to live, how to die, or how to grieve. It all depends on personal choice, and on the community with which one identifies.

Whereas the task of mourning in modernity was seen as the severing of bonds with the deceased loved one, Stroebe et al. (1996 & 1999) pointed out that mourners do not have to continue their bonds with the dead; it all depends on the individual and their unique relationship with the deceased. The dual process model (Stroebe & Schut, 1999) is a postmodern model of grief that has gained considerable attention among bereavement researchers. This model proposes that mourners do indeed need to work through their painful feelings, but they also need to learn new skills and get on with life. Crucially, the two cannot be done at the same time, so mourners oscillate between being emotion focused and task focused. A significant feature of this model is that, being oscillatory in contrast to linear stage theories, it is impossible for it to become normative: no expert or well-meaning family member can tell the mourner what is ‘normal’ after, say, six months or a year of mourning.

Ari Stillman, in a recent book about death in the online age, writes that “In an age in which we are several ‘generations removed from knowing how to be at the bedside of

the dying,' it's little wonder that 'death is a stranger in our culture'. We find ourselves akin to the prince Siddhartha Gautama, shielded by his father from witnessing suffering; yet, upon leaving the palace, he discovers sickness, old age, and death. Just as the myth of witnessing the Four Sights provoked Siddhartha's attempts to reconcile what he saw, so too do we in our day strive to find meaning in the deaths of friends and family." (Stillman, 2014, p. 44). Death as a stranger has been avoided as topic and to some degree as close experience in modern life where people tend to die in hospitals and death is hardly the subject of dinner party conversations. The world's religions have offered various precepts on eschatology, the metaphysical beliefs about death that allowed some relief of the fear of death through assurances from culturally shaped religious constructs about concepts such as the after-life. Stillman (2014) cites the anthropologist Becker who discusses thanatophobia, or the fear of death, in a cultural context. The writer reasons that postmodern grieving through social media such as Facebook isn't just a symptom of technological innovation but also grew out of an interconnected, multicultural and multi-religious world. Stillman argues that the "internet generation" (p. 45) relies on the internet and what he calls the "shared culture of Facebook" to inform how death is viewed and mourning is to take place, rather than the cultural practices of their parents and grandparents. Facebook memorial sites become "the default destination for many to express grief and remember the deceased" (p. 48). Photos and stories are shared and the deceased life celebrated online. It delocalises the deceased's final resting place in an age where family and friends may span the globe and provides a connection, albeit often a loose one, with the community of mourners.

### **3.3.2 Grief Practices as Social Constructs are Culturally Informed**

Fear and sadness are universal human emotions. But as Tobin Gonzales Barrozo, an associate chancellor at State University in St. Paul, Minnesota wrote in "Ethnic Variations in Dying, Death and Grief" (Irish, Lundquist & Jenkins Nelsen, 1993, p. xviii): "There are habits of mind and sentiments that are the products of growing up in a particular culture. Different cultures and the great world religions they embody are lenses through which reality is viewed. A lens with an amber tint reveals a world different from a world seen



through a lens of different hue. To think that all human beings experience reality the same way is ethnocentric. Dying and grief are intensely personal, yet these experiences and feelings cannot be separated from who we are and from the cultures that nourish and surround us."

Klass (1996) describe how differences in mourning behaviour might be attributable to structural differences in societies. He observes how different mourning may appear in small, closely knit communities from mourning in large, more loosely knit societies in which primary membership is in the nuclear family. In small networks such as a rural village for instance, members identify with people outside the nuclear family. When someone dies, people find substitutes for the deceased in their immediate social environment. It may be that, for instance, many adults already care for a child in a small network, and when a parent dies, other adults can easily move into the parent role. Death disrupts the social structure of small networks, so mourning rites focus on rehabilitating the damaged role system by reallocating roles. When the elder dies, someone must be moved into the role of elder. By contrast, in more complex, loosely knit networks, such as in an industrialised city, most individual deaths do not significantly affect the larger social system, so grief loses any larger social meaning and becomes a matter of individual family and mental readjustment.

Donald Irish, a co-editor of *Ethnic Variations in Dying, Death and Grief* (1993, p. 3) reminds us that there is diversity in universality. Richard A. Kalish in *Death and Dying: Views from Many Cultures* notes "Each society has developed roles, beliefs, values, ceremonies and rituals to integrate death and the process of dying into the culture as a whole and to help individuals cope with the mysteries and fears of death. And each individual must adapt these folkways to his or her own needs, wants, personality and situation." (1977, p. iii)

Tedeschi & Calhoun (2004) remark that different sociocultural groups tend to *develop particular ways of talking about and conceptualising death and the associated distress and grief*. They note how important it is to pay attention to the language used by the bereaved person. So, for instance, many in the West may talk about a person who has 'passed' or 'passed away / on' as a way of talking about a person's death. 'Their child has passed', for example, is the typical way in which some social groups describe a child's death. Some others may use phrases such as 'he's gone to be with the Lord', 'God just called him home', 'she's in heaven with her Grandma', and 'she has left us'. The authors believe that generally, the term 'died' may be the safest for a clinician to use, because it is virtually universally accepted. But the clinician should remain highly sensitive to adapt to the language and understanding of the death through the eyes of the bereaved person he or she is helping. They cite an example of a parent who replied: "I didn't lose my child. I know just where he is; DeShawn is with God. God has him safe at home with Him." (p. 49)

Tedeschi and Calhoun's heartfelt plea for cultural and individual sensitivity to the clinician working with the bereaved sums it up beautifully: "All persons are immersed in a complex network of social influences. The various cultural and subcultural groups from the individual's past and present have the potential to influence him or her in a variety of ways. The diverse, pluralistic, multicultural worlds of contemporary bereaved parents may be quite different from those of the clinicians to whom they come for help and support. Knowing what the bereaved parent's primary social groups are, the social norms the parent shares with those groups, the linguistic traditions used to talk about distress, death, and grief, the assumptions the parent makes about the clinician's status and social role, what the clinician is expected to do to be of help and support, understanding the social consequences for the parent of experiencing therapeutic change and the parent's spiritual and religious perspective-these can provide the clinician with a good grasp of the parents' experiences within their unique social contexts. General knowledge about the general cultural patterns of people belonging to broad categories such as nationalities or ethnic groups can be very useful. It is important, however, to keep in mind that even for familiar and well-established broad conceptual categories (e.g., men

and women), where general characteristics and average statistical differences may have been described by reliable observations, clinicians should always follow an admonition that is widely acknowledged and quite familiar: Focus on the individual parent and his or her unique experience and sociocultural context, not the group(s) to which that person belongs. It is important for the clinician, in order to provide the best help of which he or she is capable, to learn about the individual parent and that parent's unique sociocultural influences and environments, and to acknowledge, understand, and respect the differences between the world of the client and the world of the clinician." (Tedeschi & Calhoun, 2004. p. 49-50)

Klass (1996) contends that the task of meaning making is done in the interchange between the individual and the culture: an individual seeks to make sense of his or her experience using cognitive or mental models that are supplied by that individual's culture. As an example, when modern Western people look at sickness, they see it in terms of germs and viruses. People in other times and places might have seen sickness in terms of witchcraft or magic. According to Klass, the movement between cultural models and mental models goes in both directions and are constantly changing and evolving. He notes that the constructivist model grounds grief both in the interplay between cultural meaning and individual meaning and in concrete interpersonal relationships.

### **3.3.3 Some Examples of how Culture Shapes the Human Experience of Grief and Grieving Practices**

Grieving practices of *Native American* cultures typically centres on the natural world - the earth, the animals, the trees, and the natural spirit and on the reunion with nature that occurs with death. Common practices include the Medicine Man or spiritual leader moderating the funeral or death service, and some tribes call on their ancestors to come to join the deceased and, in effect, help in his or her transition. There is a belief that the spirit of the person never dies; therefore, sometimes sentimental things and gifts are buried with the deceased as a symbolic gesture that the person still lives. The spirit of

the person may be associated with a particular facet of nature - animal, bird, plant, water, and so forth. Symbols of such spirits may be a part of the ritual in the death ceremony. For Native Americans, it is important to ensure that the burial of the person takes place in their native homeland, so that they may join their ancestors, and so that they may also inhabit the land to which their loved ones will also return. (Athán, n.d.) Stroebe, Gergen, Gergen and Stroebe (1992) describe how certain Native American tribes such as the Hopi of Arizona encourage people to forget the deceased as quickly as possible and for life to carry on as normal. The underlying belief is that contact with death brings 'pollution' and many rites have the goal of breaking contact between mortals and spirits (p. 1207).

By contrast, continuing bonds with the deceased is encouraged in Japan where it is seen that the deceased has joined the rank of the ancestors. The on-going relationship with the deceased is facilitated by the presence of an altar in most homes, dedicated to family ancestors. Food or other gifts are offered to the ancestors. Stroebe et al. (1992) mention a study by Yamamoto and others finding that these practices facilitate adjustment to the loss. As mentioned earlier, Dennis Klass (1996) observed that the concept of emotions such as grief that are only in the individual seems foreign to the Japanese where emotions are believed to be experienced more communally.

In *Hinduism*, death is not seen as the final 'end', but is seen as a turning point in the seemingly endless journey of the indestructible 'atman' or soul through innumerable bodies of animals and people. Hence, Hinduism prohibits excessive mourning or lamentation upon death, as this can hinder the passage of the departed soul towards its journey ahead. Mourning practices begin immediately after the cremation of the body and ends on the morning of the thirteenth day. Traditionally the body is cremated within 24 hours after death; however, cremations are not held after sunset or before sunrise. Immediately after the death, an oil lamp is lit near the deceased, and this lamp is kept burning for three days. Male members of the family do not cut their hair or shave, and the female members of the family do not wash their hair until the 10th day after the

death. On the morning of the 10th day, all male members of the family shave and cut their hair, and female members wash their hair. On the morning of the thirteenth day, a fire sacrifice ceremony is held, in which offerings are given to the ancestors and to gods, to ensure the deceased has a peaceful afterlife. Typically, after the ceremony, the family cleans and washes all the idols in the family shrine; and flowers, fruits, water and purified food are offered to the gods. Then, the family is ready to break the period of mourning and return to daily life. (Bhana, 2007)

More than most other religions, *Buddhism* emphasises impermanence and ceaseless transmutation of all existing beings and forces. The emphasis is on the endless cycle of birth and death and rebirth, and the suffering that accompanies that, ultimately culminating in timeless, deathless, blissful Nirvana (Gielen, 1997). Two forms of Buddhism may be differentiated – the Higher Buddhism of the monks and Folk Buddhism that includes belief in magic and countless gods and other invisible beings that can help or harm human beings. Tibetan monks guide the deceased spirit through the perilous ‘bardo’ by reading from the *Book of the Dead*. Following bereavement family members traditionally receive much support from neighbours and extended family.

In the *Middle East* two dominant religious groups live side by side – Muslims and Jews. Each has their own cultural identity with varying expressions in thoughts and rituals depending on geographical area.

Rubin and Yasien-Esmael (2004) note that prolonged public expression of grief and ritualised mourning are discouraged in Islamic practice which places great value on the acceptance of God’s or Allah’s will with restraint and understanding. This is based on the principal that the time of death (unless by one’s own actions) is predetermined and that God has acted to set that time, therefore there is the expectation that one accepts God’s actions and will. Society’s acceptance of God’s will is manifested in an emphasis on control of emotions and limited involvement in the grief response, although the authors

note that women are granted more leeway to express their emotions. Islam prohibits the expression of grief by loud wailing though weeping for the dead (by males or females) is perfectly acceptable in Islam. Widows observe an extended mourning period of 4 months and 10 days long and grief at the death of a beloved person is seen as normal.

Rubin and Yasien-Esmael (2004, p. 155) has the following quote from the Prophet Muhammad when he lost his son, and said: "The eye weeps and the heart is sad, but we shall say nothing except what shall make Allah pleased." The Islamic religion sets forth a clear period during which one can mourn. This is generally three days and is known as 'Hidad' (mourning). During this period, the religion allows one to express grief and the expectation is that by the third day, the person will have calmed sufficiently so as to accept the loss. Younes (Chapter 10 in Cacciatore & DeFrain, 2015) notes that during the public grieving period lasting three days, the community and extended family provides support through their presence, bringing of food and prayer. Private practices are allowed that expresses the continuation of a relationship to the deceased such as giving to charity in his or her name. Theologically, one may be comforted by the belief in the continuity of the life force of the deceased. In Islam's view, earthly life is a preparation for eternal life and the soul joins God immediately upon death.

Younes (2015, p. 164) notes that common themes exist among Jews and Arabs relating to religion, the role of extended family and community, and the mourning process. With both cultures burial is done within 24 hours or as soon as possible which begins a weeklong mourning process where family and friends gather to support the bereaved family. In this time, the bereaved expresses their grief through minimal self-care such as not shaving for men. A dark ribbon or torn clothing is worn. 'Sitting Shiva' is the cultural Judaic practice of family and guests staying with the bereaved to support them, whilst daily prayers are also said. Mirrors are covered in this time. Younes mentions that, similar to Islam, Judaism holds the belief of the soul's immediate return to heaven upon death.

In *Africa* themes of bereavement are centred on ritual. Yawa (2010), who did a study of bereavement in different African cultures notes that the dead acquire the status of being called ancestors. She cites Nel (2007, p. 12) who noted that ancestors “are those elders, living and dead – of the family, clan and tribe – with whom there is a significant emotional attachment”. Yawa says “As the ancestors are called the living dead, this presupposes that the relationship between the bereaved and the *living dead* are supposed to continue to exist.” (p. 24). She elaborates that bereavement in the Xhosa traditional culture can be understood through the Xhosa saying that *Umntu ngumntu ngabantu* - a person is a person because of others. She mentions cultural bereavement practices such as that the bereaved family has to shave their heads as a sign for the mourning of the deceased. For a period of around two weeks after the burial, people sit with the bereaved and share the person’s pain, and the bereaved is expected in the first twelve months of mourning to conform to cultural norms set for bereavement. The bereavement period ends with a ritual - the *Umbuyiso* - that means “bringing the spirit of the ancestor back home.” (p. 25)

Similarly, in Zulu traditions the belief is that life goes on after death and that the person who died had gone on to be with the forefathers. As with the Xhosas, the saying *umuntu ngumuntu ngabantu* - a person is a person through other people - indicates communal interconnectedness and that the self for the amaZulu is defined in the connectedness to the community (Yawa, 2010). This of course will influence not only bereavement practices but also identity growth as examined in this study. Interestingly, rituals, rather than emotional counselling, are used to work through grief. Yawa cites Van Dyk (2001, p. 6) who states that once all the burial rituals have been fulfilled the grieving process is regarded as completed. Some rituals include the bereaved shaving their heads after the burial and according to Ritcher (referred to by Yawa, 2005, p. 1006), the hair is burnt together with the deceased clothes. This is done in order to cleanse the mourners from the pollution of death. Also from the graveside, like with the Xhosa culture, hands are washed to cleanse the death away and avoid carrying it around. Thereafter a feast is prepared for the mourners and a goat is slaughtered to celebrate the deceased’s life.

Yawa describes how, if the bereaved is a man, he is supposed to wear a strip of a black cloth. However, widows are expected to wear black mourning clothes. During this period, a widow is expected to be confined to her home for a certain period of time, which is specified by the family. A year or two after the passing, a ritual is held that invites the spirit of the deceased to be the protector of the descendants in the household.

Traditions, rather than attention to emotions, also characterise mourning in Tswana culture (Yawa, 2010). During the mourning period the mourners are expected to wear grass necklaces and shave their heads. Yawa notes (p. 33) “psychologically it would seem that in the Xhosa, Zulu and Tswana cultures the occurrence of death is something that affects the whole community not the individual or individuals concerned. It is not only one person who is bereaved but the whole community” and “unlike in the western traditional models of bereavement whereby one has to sever bonds with the deceased in order to become well, the Xhosa, Zulu and Tswana cultures promote that the bonds between the deceased and the living should be maintained.”

### **3.4 From Breaking Bonds to Continuing Bonds: how Views of Grief in the 20<sup>th</sup> Century Evolved**

*“Bereavement epitomizes the powerful confrontation of two existential givens; death and relationship. How do we remain open to others, form bonds with them, seek their company, fall in love, knowing the day will come ...?”* (Madison, 2005, p. 341)

#### **3.4.1 An Exposition of the Main Modern Western Theories of Grief during the Last Century**

*Sigmund Freud’s* immense shaping of Psychology throughout the previous century is well known. He wrote about grief and mourning in only one article, published in 1917, named ‘Mourning and Melancholia’. The article was written to distinguish and define the



difference between mourning and melancholia, with most of the article focussing on the symptoms of 'melancholia'. Freud describes mourning as a reaction to a loss of a person or connection to an idea. In grief, as opposed to melancholia, his belief is that there would be an end point and that people were capable of overcoming the condition. As Freud wrote in 1917: "We rest assured that after a lapse of time it will be overcome..." (p. 53). In his article, Freud refers to grief as a departure from the 'normal', assigning it as a temporary abnormality, as in the following statement: "...although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition and hand the mourner over to medical treatment." (Freud, 1917, p. 53.) One can only speculate about the impact this has had on the minds of therapists and the generations who were and are treated for 'symptoms' of grief by well-intended medical professionals for acting and feeling 'out of the norm'.

When Freud's daughter Sophie died, he tried to exercise the control he believed in so much, and could not allow himself the luxury of expressing his distress. Nine years later, when he learned of the death of his friend Ludwig Binswanger's son, he acknowledged in a letter to him though: "Although we know that after such a loss the acute stage of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually, this is how it should be. It is the only way of perpetuating that love which we do not want to relinquish." (Klass, Silverman & Nickman, 1996, p. 6)

*Melanie Klein*, building on Freud's theories, linked grieving to loss that occurs when a baby is weaned and that the early mourning feelings experienced at this infant stage is recalled whenever grief is experienced later in life. '*Mourning and Manic-Depressive States*' was published in 1940.

*John Bowlby's* ideas about mourning and attachment have become some of the most influential in the modern psychology of grief. Bowlby theorised that emotional difficulties could be attributed to separation anxiety in children who were not 'attached' to their mother, or mother figure (Bowlby, 1961). Mourning to Bowlby is a natural, instinctual process and takes place similarly with animals and humans. Much of his writing about mourning was focussed on pathological (maladaptive, prolonged or pining for the deceased person) mourning. Similar to Klein, Bowlby postulates that mourning is bound to occur when the child is weaned, or is removed from the mother-figure. He describes three phases through which grief progresses toward a successful resolution: disorientation, disorganization and reorganization. This description of grief phases is later echoed in many other grief theorists' ideas. He furthermore described grief reactions such as anger, despair and other emotions in detail.

Bowlby notes that grief, or mourning, is something akin to a physical illness from which we can recover and he refers to Darwin's ideas concluding that grief is an evolutionary response. (Hedtke, 2010)

*Colin Murray Parkes* (quoted in Hedtke, 2010, p. 70) emphasises the pathology of mourning as he notes in 1972 "I know of only one functional psychiatric disorder whose cause is known, whose features are distinctive, and whose course is usually predictable, and that is grief, the reaction to loss. Yet this condition has been so neglected by psychiatrists that it is not even mentioned in the indexes of most of the best-known general textbooks of psychiatry." "He references grief with an air of scientific expertise, in suggesting there is a 'predictable course' one in which the client would not surprise the knowledgeable physician." (Hedtke, 2010) The typical modern thinking is clear: mourning is objectively described as if the course of it is true for all people and cultures, and its pathology well understood by the medical fraternity. It is seen as something to be treated and overcome, and the bond with the lost loved one to be broken.

*Elisabeth Kübler-Ross* is probably the best known grief theorist in grief psychology today, even in mainstream conversation. Her book *On Death and Dying*, published in 1969, was read by many lay people, bringing the subject to the bookcases of ordinary people. Kübler-Ross' passion and compassion for the dying and the bereaved resonated with many who found her five stages of grief logical and comforting.

Kübler-Ross felt that medical practices created greater fear of death for both the patient and for medical personnel. "The more we are making advancements in science, the more we seem to fear and deny the reality of death... One of the most important facts is that dying nowadays is more gruesome in many ways, namely, more lonely, mechanical, and dehumanized." (Kübler-Ross, 1969, p. 21) Kübler-Ross was concerned with the general practice of the time by medical personnel who did not tell the terminally ill about their inevitable death, and brings a note of compassion as she hoped to "refocus on the patient as a human being, to include him in dialogues, to learn from him..." (p. 11). She furthermore described the culture of her day (and ours, to a large extent) as a death-denying culture whose members live with the illusion of immortality.

The five stages of Elizabeth Kübler-Ross's grieving model are denial, anger, bargaining, depression and acceptance; each occurring more or less sequentially. Interestingly, these five stages were described for dying patients, not their bereaved families. Bereavement does not, according to her, run in a set trajectory as is commonly assumed about her five-stage-theory. In fact, she describes an assortment of emotions such as anger and despair and the best way to deal with a bereaved person according to her, is to listen and allow them to feel and express these emotions. Kübler-Ross's model became the paradigm which is deployed in explanation and counselling of grief in all kinds of circumstances today, even in divorce or substance abuse counselling, as well as of course in counselling of the bereaved.

*William Worden* became known for his deviation from grief stages to grief tasks, a more active approach to grieving. His book, *'Grief Counseling & Grief Therapy'* (first published in 1982, and six editions since with the latest in 2009) has become well known because it describes how to have a therapeutic conversation with a bereaved person. His grief tasks are: 1) to accept the reality of the loss; 2) to work through the pain of grief; 3) to adjust to the environment in which the deceased is missing; and 4) to emotionally relocate the deceased and move on with life (1991, pp. 10-17). As can be seen, this model, though more practical and empowering to the bereaved person, still implies 'facing reality' and 'moving on', overcoming grief in other words, as if it were a sickness.

It would seem that in the twentieth century the view prevailed that successful mourning required the bereaved to emotionally detach themselves from the deceased: "Grief, as Freud saw it, freed the mourner from his or her attachments to the deceased, so that when the work of mourning was completed, mourners were free to move ahead and become involved in new relationships." (Silverman, n.d., para 2). Hedtke (2010, p. 84) notes that in the theories of grief as they developed through the past century, grief is seen as belonging to a disease model, "one that dissects its symptoms and creates cures for those suffering from this 'malady'."

### **3.4.2 Grief as a Social Construct Changes as Society Does**

Until very recently, popular Western culture held that the purpose of grief is to reconstruct the autonomous individual, who, in large measure, leaves the dead person behind. "Grief is conceptualized as an innate process that, if allowed to run its course, will bring the survivor to a new equilibrium in a changed world that no longer includes the dead person." (Klass et al., 1996, p. 5). In bereavement models developed during the past century, emotional stages and tasks are emphasised as an essential recovery process which promises a cure when one's individual status is reclaimed. In a culture that prefers that we individuate and stand on our own, the restoration of the individual self as a whole entity is revered as paramount and this has long been reflected in traditional models of bereavement (Attig, 1996; Bowlby 1980; Worden, 1991).

Silverman (n.d., par 6-8) describes how researchers Dennis Klass and Tony Walter noted that the view of grief, in which the dead were banned from the lives of those surviving them, gained popularity as interest in the afterlife waned in Western society. The growing influence of the scientific worldview in the twentieth century led to death being viewed as a medical failure or accident rather than as an inevitable part of the human condition. In the same vein, the physician George Lundberg wrote about the difficulties caused by the expectations of both physicians and those they serve that they can keep death away rather than accepting that death is both natural and inevitable. Parkes (2003, par. 1) writes “Much of the writing on the subject of bereavement during the first three quarters of the twentieth century were written from the point of view of western psychiatrists. As such it presented a reasonably consistent view but one limited by a frame of reference which has been primarily concerned to identify risks to mental health and prevent psychiatric problems.”

Moreover, the twentieth-century Western approach to human behaviour that valued individuation and autonomy also supported the focus on detachment. In this context, Bowlby developed his theory of attachment behaviour in children, focussing on the individual and how his or her needs could be met. Bowlby believed that our emotional bonds ‘arise out of deep seated innate mechanisms which have evolved in order to ensure survival’ (Parkes, 1993, p. 246).

Silverman (n.d.) further notes that as Bowlby’s theory was subsequently applied to bereavement theory, the interactive, relational aspects of the process were not clearly spelled out. In the ‘letting go’ model, a linear view is used, as if one experience can lead to one outcome, and this is how attachment theory was often applied as well.

Worden and Worden noted that the process of bereavement by some may have seemed as having the function of enabling the bereaved to detach themselves from the lost

person, but notes that others have seen it as enabling them to find an appropriate place for the dead in their emotional lives (Worden & Worden, 1992).

Jerome Bruner, a psychiatrist, notes that people can rarely be put into a simple cause-and-effect model. There are simply too many intervening variables reflecting the complexity of real life (Bruner, 1990). In a linear model, bereavement is seen as a psychological condition or illness from which people could recover with the right treatment. Regrettably, the fact that bereavement is a difficult yet inescapable part of the normal life cycle seems to be ignored. Bereavement is a period of loss with all the accompanying emotions of sadness, grief, guilt, anger and heartache, but it is not an illness, it is a natural part of living. Bereavement can in fact be a time of growth and identity enrichment, a time of change and transition in how the bereaved relate to themselves, to the deceased, and to the world around them.

Soon before the turn of the century, views of bereavement seemed to evolve. A growing recognition of the complexity of the human condition and the importance of relationships in people's lives came more to the fore. The goal of development slowly seems to shift to recognition of interdependence rather than extreme emphasis on independence. Consequently, relationships with others, living or deceased, frame one's sense of self and how one lives (Silverman, n.d.).

### **3.4.3 New Thoughts Emerging**

Dillenburg & Keenan (2005) observe that the endeavour to understand the complex process of bereavement has moved from intra-psychic explanations and stage theories to cognitive rationalizations and, most recently, process orientated explorations of bereavement.

“The view of grief most accepted in this century holds that for successful mourning to take place the mourner must disengage from the deceased, and let go of the past... To experience a continuing bond with the deceased in the present has been thought of as symptomatic of psychological problems.... A continued attachment to the deceased was called unresolved grief.” (Klass et al., 1996, p. 4)

In Western scientific literature Freud’s ideas of an unavoidable grieving process or ‘grief work’ that serves to end emotional and internal attachments to a love object, and the necessarily detrimental effects of not going through the natural path of grieving, have had a massive and extremely long lasting influence on thinking in the area (Worden, 1991). Grieving was also understood in terms of stages that the bereaved has to go through in order to adjust to the loss (Stroebe, 1998). Often these stages were described as following a relatively uniform sequence of shock, denial, depression, anger, regaining equilibrium or homeostasis, and recovery or resolution. Dillenburger & Keenan, (2005) discuss various writers who postulated several stages through the years such as Rubin (in 1977) and Tatelbaum (in 1981) who postulated three stages, Conroy (in 1977) and Bowlby (in 1980)’s description of four; Kübler-Ross (in 1969) and Littlewood (in 1986) who outlined five stages, and Calhoun, Selby, and King (in 1976) who used six categories, while Lipinski (in 1980) depicted seven stages of grief.

Pathologising of ongoing bonds with the deceased sometimes lead to some brutal techniques. Volkan in 1968 (in Klass et al., 1996, p. 5) ‘treated’ a 16-year-old girl whose mother had committed suicide. Instead of allowing the girl to talk about her mother, Volkan talked about her mother as an ‘inanimate object’ consisting of degenerating anatomic structures such as skin, muscle and bone, to ‘hasten the return to normality.’ Klass et al. remark that this model of grief where continued bonds with the deceased is denied, is a 20<sup>th</sup> century phenomenon.

In the early 1990s clinicians became disenchanted with the almost prescriptive stages a person had to progress through, and new developments in grief theories gained momentum. The Grief Wheel (Goodall, Drage, & Bell, 2003) for instance, suggested there are no clear-cut dividing lines between each stage of the grieving process but that each phase merges into the next with some movement backwards and forwards. Dillenburg (1992) (in Dillenburg & Keenan, 2005) distinguish between changes linked to the loss itself (primary changes), and secondary changes which are more controllable and can actually be influenced.

Consequently, the Dual Process Model (DPM) of Stroebe & Schut (1999) evolved as a dominant concept of coping. DPM was concerned broadly with two processes in bereavement: loss and restoration. They suggested that a loss orientation primarily represented emotional and mental coping with the loss, and restoration orientation referred to dealing with practicalities, coping with changes in everyday life, and taking on new roles.

In stark contrast to earlier modernist or positivist views which focus on breaking bonds and universal symptoms and stages of adaptation to loss, the *postmodern social constructionist approach views continuing bonds* as resources for enriched functioning and the oscillation between avoiding and engaging with grief work as fundamental to grieving (Neimeyer, 2001).

Recently, more integrative frameworks emerged and the concept that detachment from the deceased is the desired outcome of grieving has been challenged. Silvermann and Klass (1996) suggested continuing bonds with deceased loved ones. Walter (1997) also believes that the purpose of grief is not severing the bonds with the deceased but rather the construction of long-lasting, durable biographies in which the memory of the deceased is integrated into the life of the bereaved. He suggests that the process through which this is achieved is based on conversations with those who knew the deceased.



Stroebe et al. (1992) discuss research that, despite the prevailing culture of what they term 'the breaking bonds orientation', many have found that in the minds of the bereaved, the persistence of the ties with the deceased continued. The Tubingen Longitudinal Study of Bereavement provided evidence for instance that a third of their sample sensed their spouses' presence after two years, and 'consulted' with them in decision making and planning, gaining comfort from the continued relationship in their lives. Similar results in an American study by Schuchter & Zisook (in Stroebe & Gergen, 1992) noted a number of ways in which the relationship with the deceased spouse is cherished and nurtured: "the empirical reality is that people do not relinquish their ties to the deceased, withdraw their cathexis, or 'let them go.' What occurs for survivors is a transformation from what had been a relationship operating on several levels of actual, symbolic, internalized and imagined relatedness to one in which the actual ('living and breathing') relationship has been lost, but the other forms remain or may even develop in more elaborate forms." (p. 14)

Stroebe & Gergen (1992) also describe how children who have lost a parent maintain a sense of presence of the parent in their lives by talking to the parent, keeping mementos, visiting the parent and so on. Children may also maintain a relationship with a deceased parent by letting their behaviour be guided by what they believe would have made their parent proud. It seems that maintaining an on-going relationship with a deceased loved one for some is perfectly natural and not necessarily indicative of pathology or unresolved grief at all.

In the past decade or two, the idea of bereavement as an illness from which a person needs to be cured through various ways, has been increasingly challenged. Archer (1999) argues that grief is a natural reaction to the loss of a relationship. He points out that we develop our identities based on sets of ideas closely linked to those who are dear to us like families and friends. These ideas are resistant to change and naturally a struggle ensues when we lose what we love. Reductionist concepts of grief are becoming less

acceptable and theories that take cognisance of the variety of the human experience of grief, the society in which the bereaved person lives, and the nature of the relationship are emerging.

### **3.5 Narrative Therapy as Postmodern Bereavement Model**

#### **3.5.1 Moving away from Grief as a Disorder with Stages and Tasks**

Bereavement counselling in the modern 20<sup>th</sup> century has traditionally focused on what has been lost and the pain associated with it, and has often delineated stages and tasks to describe how grief should manifest. This has guided clinicians, and often lay thinking as well, to think about clients as living with a rigid trajectory of grief. The danger in this is that we can promote iatrogenic injury (inadvertently caused by a physician or surgeon) (O’Hanlon, 1993, in Hedtke, 2002) by entrenching a person in stories of sadness and loss when we expect a person to dwell in emotions like sadness, anger and denial for a certain period of time in prescribed ways.

Modern theories of grief therapy aim to relieve a person of their ailment, i.e. grief. These understandings of bereavement may allow for individualised response to their specific loss, but the process of resolving their bereavement is based upon the expectation of a predictable template, that is observable by mental health professionals. Thus we have expectations and theoretical concepts of what is considered normal regarding bereavement, and the mental health professional would then be able to discern so-called risk factors that predict a greater likelihood of ‘complicated bereavement’ and even diagnoses of ‘pathological, unresolved, grief’. An example of this practice is the tendency to pathologise as ‘denial’ or ‘separation anxiety’ reports by the bereaved that the deceased may be seen, heard, or conferred with, despite indications that these occurrences may in fact be comforting and reassuring for the bereaved (Madison, 2005). Hedtke (2002, p. 2) remarks that “the psychological models that foster this way of thinking assume that if we face our pain and indulge our emotions, we will

prevail and move forward to a new and better place - a place adjusted to life without our loved one.”

Madison (2005) notes that the orthodox theories of Parkes, Bowlby, Worden and Kubler-Ross are being challenged and modified according to a more generally postmodern, and in some respects, existential, approach to understanding of grief therapy. Modernist clinical assumptions regarding healthy outcomes are relativised as one possibility among many.

Silverman & Klass do not see bereavement or grieving as ever fully resolved, culminating in ‘closure’ or ‘recovery’. They propose that rather than emphasising letting go, the emphasis should be on negotiating and renegotiating the meaning of the loss over time. While the death is permanent and unchanging, the process and relationship, are not (1996, p. 18).

### **3.5.2 A Continuing Relationship with the Person who Died**

The postmodern grief concept of continuing bonds is an idea that represents recognition that death ends a life, not necessarily a relationship. Hall (2011, par. 15) contends that the development of this bond is conscious, dynamic and changing. “The expression of this continuing bond can be found in a variety of forms. The deceased may be seen as a role model and the bereaved may turn to the deceased for guidance or to assist them in clarifying values. The relationship with the deceased may be developed by talking to the deceased or by re-locating the deceased in heaven, inside themselves or joined with others whom they pre-deceased. The bereaved may experience the deceased in their dreams, by visiting the grave, feeling the presence of the deceased or through participating in rituals or linking objects. Many people build the connection out of the fabric of daily life. Frequently this continuing bond can be co-created with others.”

Hedtke (2010, p. 146) explains: “By maintaining that not everything has to die when a person dies, we can create conversations that give people something to hold on to. In the moments of crisis that often accompany grief, holding onto remembered stories can be comforting and reassuring. There are many variations of what might be helpful to remember: such as a story of what a person loved, a story about his or her kindness, or something great he or she had done. Whatever a person selects to remember can serve to mark the deceased person’s life as significant.”

If we employ a postmodern narrative perspective, it is possible to retain a relationship with the deceased whilst overcoming the indicators normally associated with grief (such as depression or anxiety). Narrative Therapy allows us to speak about what remains (rather than just about what is lost) after a person has died. In postmodern grief therapy, the maintained presence of the deceased in the circle of family and friends is established by allowing space for a continuing role for them within the lives of the bereaved (Madison, 2005). An example of this is given by Walter (1997, p. 10) quoted by Madison where bereaved parents may indicate the deceased child’s on-going presence in the family with statements such as, “We’ve got three children, one of whom has died” (Madison, 2005, p. 341).

Walter (1997) has argued that the purpose of grief is not severing the bonds with the deceased but rather the construction of long-lasting, durable biographies in which the memory of the deceased is integrated into the life of the bereaved. He suggests that the process through which this is achieved is based on conversations with those who knew the deceased. Hedtke (2010) concurs when she notes that “The event of death need not indicate an endpoint to relationship.” (p. 146) Also, from this perspective, there is no unnecessary pressure to complete all unfinished business in deathbed conversations before a person dies. The stories, memories of good times, relationship rituals, favourite sayings, cherished songs, shared connections with others, and accounts of how life challenges have been met all remain in memory. She points out that more than just comforting, these narrative elements actually help the living maintain a sense of

connection with the deceased and can become a resource for the bereaved in the living of their own lives as these elements continue to be folded into the memory of the living.

The phrase 'continuing bonds' was first used in 1996 by Silvermann and Klass to refer to an aspect of bereavement process in the title of the book, *Continuing Bonds: Another View of Grief*, which challenged the popular model of grief requiring the bereaved to let go of, or detach, from the deceased. It was clear from the data presented that the bereaved maintain a link with the deceased that leads to the construction of a new relationship with him or her. This relationship continues and changes over time, typically providing the bereaved with comfort and solace. Silverman (n.d.) describes how Natasha Wagner, whose mother, the actress Natalie Wood, drowned when Natasha was a teenager, spontaneously expressed: "I had to learn to have a relationship with someone who wasn't there anymore", and how, after the death of his first wife, playwright Robert Anderson wrote about her continued place in his life: "I have a new life. . . . Death ends a life, but it does not end a relationship, which struggles on in the survivor's mind toward some resolution which it never finds". (par. 2)

Children who have lost a parent maintain an internal bond to the person who has died. Memories of the parent do not stay fixed or static; they are active and ever-evolving representations which change over time. Marwit and Klass (1994) published research on adolescents and children who had lost a parent. They found that the deceased continued to act as a role model, a source of guidance, someone to help clarify issues and someone who brings comfort. Ambivalence towards the deceased was not seen to be problematic or indicative of early development failure.

Narratives are stories and people make sense of their lives by telling a story that makes sense of their past and present experiences. Whether they are aware of it or not, people have an autobiography that they are constantly revising in light of new experiences. Sometimes death forces one to see the world differently, and when a person sees the

world differently, he or she constructs a new narrative, a new biography of themselves and of the person who has died. The life of the deceased can continue in a storied form. Ideas and stories are seen as social constructs where more than one person can contribute and shape the stories of (a) life. “There is a sense, for example, in which the life of Beethoven continues in his music or Shakespeare in the performance of his plays. The same can be true for many people who live more modest lives. There are many possibilities for relationship to be continued through the remembering and retelling of the stories in which a person’s life has been lived.” (Hedtke, 2010, p. 21)

“...death may be understood from a postmodern perspective, and responded to, primarily as an event in a relationship, rather than primarily as an event in the life of a lone individual” and “The attempt here is to treat grief as a relational transition rather than just as a process in an individual’s inner experience and emotional state.” (Hedtke, 2010, p. 304)

Stories shape our identities and our social interactions and give meaning to our worlds. In grief counselling using narrative therapeutic discourse, a person may uphold a story, or sustain a relational interaction, long after a person has died. A person may also change the way the story is told, or unfolds, thereby reinterpreting a relationship and events as needed.

### **3.5.3            Saying ‘Hello’ Again: Reincorporating the Loved one in a New Way**

Michael White’s seminal article, *Saying Hello Again* (1988), refers to ‘reincorporation’ of the person who has died. In the title of the article, White confronts the assumption in modern grief counselling that the bereaved must say goodbye to those who have died. White (1988) found that approach created distress for clients. “Focusing on what remains, rather than only what is lost when a person dies, has a therapeutic effect because it re-establishes a storied connection to those who have passed.” (Hedtke, 2010, p. 6)

Rather than pursuing conversations of completion and letting go, White explained how he endeavoured through the 'Saying Hello' metaphor to guide a new line of inquiry. He hoped to open up possibilities where the relationship between the deceased and the living could be reclaimed. In his article (1988) White challenges the cultural assumptions prescribing emotional distance between the living and the deceased. By remembering and reaffirming stories about the relationship between a person and their loved one, the deceased loved one becomes linguistically accessible to the client here and now. The hypothesis is that this relieves the pain of separation when the client attempted to 'say goodbye'.

White concluded in the article that the careful reincorporation of the lost relationship resolves what has been thought of as 'pathological mourning' or 'delayed grief'. In this process, the bereaved client also gains the opportunity to grow in a new relationship with her or his self, one that engages in a re-authoring of life to include the hopes and dreams and stories of the deceased.

#### **3.5.4 An On-Going Bond with Remembering Practices**

In White's 1997 book *Narratives of Therapists' Lives* he expanded on the idea of healing through remembering ideas and practices. The connection between the concept of membership and the act of reincorporation to strengthen preferred stories of identity became clearer. Instead of asking of the bereaved to say goodbye to deceased loved ones, this approach encourages them to stay connected to the deceased through stories and to actively remember them. Stories are selected by the bereaved to draw on the most helpful aspects of relationship.

A term used to describe the on-going bond between loved ones is the term *remembering*. White borrowed from Myerhoff who named these conversations and acts

as 'remembering practices'. Myerhoff (1982) explained the importance of the phrase: "To signify this special type of recollection, the term 're-membering' may be used, calling attention to the reaggregation of members, the figures who belong to one's life story, one's own prior selves, as well as significant others who are part of the story. Re-membering, then, is a purposive, significant unification, quite different from the passive, continuous fragmentary flickerings of images and feelings that accompany other activities in the normal flow of consciousness." (p. 111.)

Re-membering in this sense thus encompasses both *recalling* as well as the *inclusion of the deceased as members of the living*. Hedtke (2010, p. 140) notes "In a sense, membership and narrative have the ability to transcend death." And (p. 141): "The continued telling of stories creates an ongoing relationship, and in fact, may encourage a new appreciation of relationship. The task for the living is to find place for the voice and the stories of the dead to live and to reverberate in the club."

Lorraine Hedtke (2010 and 2002) points out that the language used in popular culture and condolence cards, is often along the lines of 'we are sorry for your loss, your loved one is in a better place, time will heal your sorrow' and so on. This, she believes, is what she calls "dismembering language" (2002, p. 5), encourages disenfranchisement from the relationship and speaking poignantly about letting go and moving on (practices that she emphasises dis-member our loved ones) from the grieving. She would much rather see cards that encourages remembering, appreciating and storytelling, cards that are printed with 'I remember a time when....' or 'I loved this about your deceased family member'. This would acknowledge the continuous connection between the dead and the living. In Narrative Therapy, a safe space is created where the emotions of grief may be experienced, but also where the stories that give meaning to the client's life and identity explored, stories that incorporate the deceased and the living as members of the same 'tribe' or family.



Klass et al. (1996) write that if we look to perpetuate relationship, we must look to find the paths that promote relationship rather than the renewal of individual status. Hedtke (2002, p. 7) describes that in Narrative grief counselling, she encourages people to speak about their loved one who has passed on, to share stories about him or her, to ask others about what they recalled that they enjoyed about them, and she encourages them to actively create rituals and celebrations for holidays and anniversaries. As part of developing the connections further, she goes as far as inviting her clients to introduce their loved one to people who may never have had the chance to know them during life.

Klass (in Klass et al., 1996) believes that the resolution of grief includes cultivating bonds of emotion and meaning with the dead. In other words, people who are important to us become part of our inner conversation and remain there after they die. If someone says, 'I would not do that because my mother would be disappointed in me', the mother is part of that person's inner conversation even though the mother is not present and may never find out if the person did it or not. So often one hears a man wondering if his deceased father would have been proud of him. His father, to him, is alive and a member of his family, whether he is physically present or not. People who are important to us may continue to play important roles in our lives and in the life of the community for many years after they have died. Klass et al. emphasise that throughout history this kind of persistent communion with the dead is a recurring behavioural pattern, far more common than an outright severing of all bonds (Klass et al., 1996).

In a similar vein, Cottor and Cottor (1999) remark that if our stories are stronger than our biology, then the narrative themes and plots play forth often whether we are present or not. They explain that as we choose the stories we want to tell, we produce different nuances and strengths for our relationships to develop over the years. Using narrative or story is furthermore a useful vehicle for making sense of difficult experiences in life, allowing alternative narratives and interpretations, and enabling richer self-knowledge.

Zisook and Shear (2009) also point out that grief is not only about separation from the person who died, but about finding new and meaningful ways of continuing the relationship with the deceased. "Faced with the dilemma of balancing inner and outer realities, the bereaved gradually learn to accept the loved one back into their lives as deceased. What occurs for survivors is the transformation of a relationship that had heretofore operated on several levels of actual, symbolic, internalized, and imagined relatedness to one in which the actual (living and breathing) relationship has been lost." (p. 71). Other forms of the relationship remain, and continue to evolve and change. And so, as psychiatrists they point out that it is perfectly normal and not at all unusual for bereaved individuals to dream of their deceased loved ones, to half look for them in crowds, to sense their presence, feel them watching out for or protecting them, to rehearse discussions or speak to them. Auditory or visual hallucinations of the deceased person are often seen during acute grief. Sometimes people maintain a sense of connection through objects such as clothing, writings, favourite possessions, and rings, which may be kept indefinitely. Zisook and Shear (2009) describe how some people continue a relationship with the deceased through living legacies, such as identification phenomena, carrying out the deceased's mission, memorial donations, or seeing them live on in others through offspring. For others, periodically visiting the grave or lighting candles may help keep memories alive. They point out to clinicians that bereaved individuals may in fact take some comfort in learning that the relationship does not need to be totally severed, but that it is perfectly acceptable and even normal for the relationship to endure indefinitely.

### **3.5.5 A Respectful Stance**

One of the tenets of Postmodernism is an admission that the concepts we may hold true today, or in our culture, are historically bound and culturally constructed. From that stance, an 'expert' clinician remains humbly aware that he or she can never be the ultimate expert on any topic, let alone a topic as individually experienced as grief. Nor can the clinician claim to be an expert about the bereaved person they are hoping to help.

Tedeschi and Calhoun (2004) prefer the term '*expert companion*' to explain the role of the helping clinician to the bereaved. In a chapter about counselling bereaved parents, they observe: "For those of us who are not bereaved parents, it is dangerous therapeutically to claim expertise in this area, given how many parents are clear that only another bereaved parent truly understands. We believe that they are right. It is probably impossible to know the particulars of this pain without going through this, even if you have heard many stories as we have, or try your hardest to be empathic. Even if clinicians themselves are bereaved parents, their own experience and cultural contexts can diverge from that of other parents." (p. 51) Yet, the authors emphasise that there is indeed expertise and helpful knowledge in this field that the clinician should have: "We are making the case that the expertise is primarily involved in being a high-quality companion in bereavement, and that the expertise is woven into your interactions, rather than revealed through knowledge of facts or intervention procedures that heal the pain of grief." (p. 51)

"This kind of respect for the bereaved parent is powerful. With your attention and recognition of the limitations of your abilities, you acknowledge how profound this loss is, and how much it takes to endure it." (Tedeschi and Calhoun 2004, p. 56)

When it comes to grief therapy in this study, a reclaiming of a client's sense of self, emotional wellbeing and way of being in the world is encouraged by a full and rich description of the grief experience as an experience not problematic within the person self, but an experience that may bring growth. The experience of loss is then re-authored through Narrative Therapy in alignment with a new emerging identity. In a narrative practice with death and grief, remembering, inclusion and building on-going connections are valued and supported. The focus is on the practical and positive tasks of constructing effective conversations to re-establish and strengthen membership with loved ones who passed on. The growth that takes place in the bereaved person is explored, leading to a new relationship with the loved one – not just because the person

is no longer physically there, but also because the bereaved person finds themselves changed through the process.

### **3.6 Identity Growth and Meaning-Making in the Process of Bereavement**

Victor Frankl argues in his influential work *'Man's Search for Meaning'* (published in 1962, cited in Gillies & Neimeyer, 2006) that people are driven by a psychological need to find or create *a sense of meaning and purpose in their lives* and that this drive can facilitate their capacity to face and transcend even the most horrific experiences. Klass et al. (1996) suggest that beyond instinctual responses lie the realm of thought or meaning, which has been excluded from many definitions of both grief and mourning. They believe that when a significant person dies, the issue of meaning is central for the survivors.

Questions invariably arise - What does this death mean? What does this life mean? What did this person mean to me and to this community? Individuals who try come to terms with a traumatic death may change how they think about themselves, how they relate to others, and how they view life in general. What is the meaning of the loss? What did the loss bring to the life of the bereaved? What did it teach? Did it bring wisdom? Did it bring life lessons? Does the bereaved person do things differently after the loss? Do they believe differently? Has it changed the way they relate to family and friends, to themselves?

People make sense of their lives by telling a story, or if you will, a narrative, that makes sense of their past and present experiences. Whether they are aware of it or not, people have an autobiography that they are constantly revising in light of new experiences. Klass notes that "If something like an important death does not make sense, it is 'nonsense.' Both individuals and societies want to keep seeing the world the same way, but sometimes death forces one to see the world differently. When an individual sees the world differently, he or she constructs a new narrative, a new biography of themselves and of the person who has died." (Klass et al., 1996, p. 5)

Since meaning derives from the recognition of a fit between the world we shape in our minds, and the world which we meet, any discrepancy is experienced as loss of meaning. When a family loses a child, or a parent, this discrepancy forces every family member to reconsider everything that they hold true. The whole family culture changes when one of its members dies, and in this sudden crisis a family and the individuals it consists of, can either stay stuck in guilt or denial, or build new meaning in the creative void left. By the same token anything which helps to restore the fit between the world that is and the world that should be is accompanied by an enhancement of meaning (Parkes 1993).

M.S. Stroebe (in Stroebe & Shut, 1999) describes what she calls a Dual Process Model of coping with bereavement. The psychological processes during the 'Loss Orientation' following death is when a person cries out for their dead loved one, searches for him or her, despite their logical mind knowing that it is not possible to encounter them in the same form (one also sometimes encounter this behaviour with animals.) This process of psychosocial transition occurs whenever people are faced with an event which invalidates a large part of our assumptive world (the world which we assume to exist on the basis of our experience of life). During the 'Restoration Orientation' the person is gradually able to change their assumptions about the world in keeping with the new situation which now exists. In the normal course of events bereaved people oscillate between these two orientations as they work through the process of relearning.

Parkes (2003) points out that Stroebe's model fits well with current social constructivist thinking which asserts that the assumptive world is a psychological construction which is radically shaken by any major loss. He quotes Frankenberg in his review of Peter Marris' work (*Cogito ergo doleo*, 1996, p. 2): "the present appears to be made structural, functional and meaningful by contemplation of the past, but . . . when the imagined future suddenly disappears, the present is torn apart and fragmented by the realisation . . . of continuity and the acceptance of inevitable change."

Psychiatrist and author Preller (personal conversation, 7/7/2011) concurs: when a person loses a loved one, everything they held onto in their interpersonal identity is shaken to the core, and they find themselves adrift, after having defined themselves partly by their relationship to the person they lost. It is only once they have created meaning again that equilibrium returns. The psychiatrist John Bowlby wrote that a discussion of mourning without identification - that is, finding a place for the deceased in one's sense of self - will seem like Hamlet without a prince (Silverman, n.d.). (Bowlby however, believed that when attachment to the deceased is prominent, it may be indicative of psychopathology.)

Parkes (2003) describes research done by Kate Bennett suggesting that in older widows the effects of bereavement in later life are more marked and more long lasting than has been previously recognised. Although depression declines and mood improves in the long term neither of these returns to baseline levels. Her study of elderly widowers showed them to be more vulnerable to social disengagement than other widows. Madison (2005, p. 348) notes "counselling can act as a 'rehearsal' for renegotiating significant relationships in that world in a more honest and satisfying way."

Various grief writers described the grief process diversely as part of a reconstructive process of psychosocial transition (Parkes, 1996), what Tony Walter calls biography, Margaret Stroebe calls a process of restoration, Riches and Dawson describe as rethinking lives, roles and relationships, David Balk calls reminiscence, Arnar Arnasson (with Neimeyer) calls narrative and Worden called a process to find an appropriate place for the dead in their emotional lives. Each of these concepts adds something to our understanding of an aspect of loss, though Collin Murray Parkes contends that we should not lose sight of the grieving individual going through a deeply traumatic experience, and our task is to respond with caring and compassion. (Parkes, 2003)

So much of our identity is tied to our bodies, to our age and gender and nation, to the roles we play in life – as parents, workers, children, students, citizens or people belonging

to a particular cultural and religious group. Preller, (2015) notes that life is a struggle to create and preserve our identity, shaped and maintained by interpersonal interactions. We guard our identities carefully, jealously, as we traverse life like a boat between huge rocks in the ocean. It is so precious to us that without it we feel lost and anxious. Preller explains identity according to the theory of Sullivan thus: our identities are our way of protecting ourselves from the anxiety we feel in our interaction with others. We feel anxiety not just with the fearful and mysterious concept of death, but we also have to face going on, staying alive, developing a new sense of who we are and living when we feel like dying ourselves.

Sometimes in the midst of grief, people develop symptoms that mimic the cause of death of their loved one, such as developing chest pains after their loved one passed from a heart attack. It is often daunting to face a life without a loved one, it is also often overwhelming to grow into the new roles we literally have to live up to.

Therefore, when we lose a loved one, we grieve not only for the loss of that person in our lives, but we are unsettled by the sudden identity change that is thrust upon us. A wife becomes a widow, and head of her household and home, a daughter loses her father, and suddenly has to make decisions she would have relied upon him to make for her, a woman loses her jealous and abusive husband, and has to face the freedom that comes from being able to socialise without having to explain herself. Losing a loved one sometimes means taking over some of the role that person played, and making it part of our identity. Indeed, losing a loved one, and working through our grief, can lead to *identity growth*. The questions invariably need to be faced: who am I if I am not so and so's wife, or daughter, or husband? Who am I if I now have to take over the main decision-making in a household, or define myself as a widower? What implications do these have for my role in my extended family, and in my community?

“Although initially these new roles can be burdensome, they can often open the bereaved to a third domain of growth, *new possibilities* they had little or no experience with before. Loss also can open up the possibility of new relationships. Of course the person who has died cannot be directly replaced, and bereaved persons seldom wish to think this way, but the vacancy produced in the bereaved person’s life allows for new people to enter.” (Calhoun, Tedeschi, Cann and Hanks, 2010, p. 128)

The growth that this necessarily brings means recognition of previously undiscovered strengths and talents, previously hidden parts of the personality. And as a person changes and starts enacting some of the roles that their loved one once embodied, and more, becoming perhaps more compassionate, or strong, a person cannot avoid relating differently to others. Very often this means a change in how one relates to extended family members, colleagues, other bereaved people, and friends. Calhoun et al. (2010) has found that the bereaved often develops a greater sense of closeness and a general feeling of greater compassion toward others in general, or to others who share similar difficult losses.

Calhoun et al. (2010) calls the positive outcomes that can follow grief and other upsetting experiences “posttraumatic growth”. They make particular mention of changes in self-perception: “The change in self-concept that reflects growth can be summarised with the somewhat paradoxical phrase *more vulnerable, yet stronger*” (p. 127) and “As one bereaved parent told us: ‘I’ve been through the absolute worst that I know. And no matter what happens, I’ll be able to deal with it.’” (p. 128).

Some people make meaning of their loss by channelling their energy into ventures related to their loss. It is well known that many support organisations have been started by family members or parents who suffered a loss through some disease.



Dominick Dunne, the famous investigative journalist, channelled his grief into exposing criminals after his daughter, Dominique, had been strangled by a former boyfriend. This was his way of bringing the experiences learned during the trial of her murderer, and his then new found talent for journalism, to new meaning in his life.

The world is full of charities started by bereaved parents, or scholarships set up in a loved one's name. The Ribbons of Hope for instance is a charity organisation started by a group of friends affected by women's cancers who raise money for a network of cancer support centres for people living with cancer and their loved ones (<http://www.wellspring.ca/Sunnybrook/Home.aspx>). The Michael's Feat charity was set up by a couple who lost their new-born son Michael. This charity raises awareness and provides support for families going through similar situations with seriously ill or premature new-borns. (<http://atlanticville.gmnews.com/news/2011-03-10/Front Page/Michaels Feat supports ill newborns and families.html>) Likewise, the Drowning Support Network (<http://drowningsupportnetwork.wordpress.com/>) was a chance for bereaved parents to provide support for similarly grieving family members. These are all examples of courageous people making meaning out of a loss that may seem senseless at first.

Walter (1997) describes bereavement as the never-ending and reflexive conversation with self and others through which the late-modern person makes sense of their existence. He notes that there seems to be general agreement that bereaved people need to talk their way through grief. Collin Murray Parkes (2003) pleads for a deeply compassionate view of the bereaved, and also notes the power of talking through emotions, whatever theory of grief one holds. Anderson & Goolishian (1988) contend that meaning and understanding are socially constructed between individuals when they engage in meaning-generating dialogue such as might happen in therapeutic conversations.

Strang, (2001) (in Dillenburg & Keenan, 2005, p. 92) remarks that “The death of someone close is, for many, the most devastating experience in life. Most people find ways of adjusting to their loss; for others it may be too difficult without additional support.” As clinicians we need to remain sensitive both to how devastating a loss can be, but also paradoxically, how much of an opportunity for growth it can be.

Harold Kushner, who wrote ‘When bad things happen to good people’, sums it up “I am a more sensitive person, a more effective pastor, a more sympathetic counselor because of Aaron's life and death than I would ever have been without it. And I would give up all of those gains in a second if I could have my son back. If I could choose, I would forego all of the spiritual growth and depth which has come my way because of our experiences, and be what I was fifteen years ago, an average rabbi, an indifferent counselor, helping some people and unable to help others, and the father of a bright, happy boy. But I cannot choose.” (cited in Tedeschi & Calhoun, 2004, p. 54)

Various authors (Balk, 1999; Cutcliffe, 2004, Lendrum & Syme, 2004, Novick, 2007, Worden, 1992 etc) recognise how sensitive a clinician should be to the role of spirituality in the lives of the bereaved. For some grieving people, it has brought a new appreciation of the role of their beliefs in the transcendental or metaphysical in their lives. Religion and spirituality may serve as a framework promoting growth through an increased sense of meaning and purpose (Rogers et al., 2008). Balk (1999) discussed finding meaning in one's life following a loved one's death and that this can represent a spiritual change that may result from bereavement. Calhoun et al. (2010) cite Batten and Oltjenbruns (1999) remarking that the often-difficult experience of losing a loved one can challenge the belief that events in one's life have meaning. The authors observe that this disruption may initiate a process of re-examination of important components of the assumptive world. They also cite a study by Znoj (published in 2006) of a group of bereaved parents, for whom spiritual coping was found to be among the top three predictors of posttraumatic growth, suggesting a possible avenue towards growth.

Perhaps one of the most profound ways grief changes us for the better is the realisation of how brief and therefore precious life is. “This *appreciation of life*, living it more vividly, may be difficult for some people to sustain, but it is sometimes consolidated into new habits of living more deliberately rather than routinely.” (Calhoun et al., 2010, p. 128)

*It's only when we truly know and understand that we have a limited time on earth -- and that we have no way of knowing when our time is up -- that we will begin to live each day to the fullest, as if it was the only one we had.* - Elisabeth Kubler-Ross (Elisabeth Kubler-Ross Foundation)

*“The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen.”*

Elisabeth Kubler-Ross (Death: The Final Stage of Growth, 1975, cited in Elisabeth Kubler-Ross Foundation)

### **3.6.1 Some Thoughts on the Facilitation of Growth**

Calhoun et al. (2010) note that the observation of post traumatic growth is an ancient one. They have a caveat however: “Posttraumatic growth clearly occurs in a context of significant life challenges, with concomitant states of psychological distress and sometimes great suffering. It would be a gross misinterpretation of what we are saying to assume that the focus on growth minimises the importance of attending to the negative responses that for many can accompany the experience of loss.” (p. 127)

Calhoun and several co-authors have written prolifically about the concept of growth following loss and trauma as well as how to assess it. Below are some of their thoughts on how to facilitate this growth (from Calhoun et al., 2010):



### *Humility and respect, not platitudes*

The clinical stance of the helping person (called 'expert companion' by the authors) should be one of a basic respect for the beliefs and experiences of bereaved persons, often rooted in their culturally-based understandings of death and grief. This, the authors believe, is essential to setting the stage for posttraumatic growth. Instead of seeking to merely provide comfort and reassurance with platitudes, that are often given by well-meaning friends and family, the clinician working as an expert companion is willing to explore these beliefs, and the doubts about them, that may be raised by the experiences of the bereaved.

### *Constancy*

The clinician is willing to tolerate the fact that bereavement can be a longer-term process than what is expected by friends and family, or the bereaved persons themselves. Stroebe & Schut (1999) emphasise that the clinician is a constant in spite of oscillations in the grief experience of the individual.

### *Tolerance of the strange, non-rational, and ambiguous*

Experiences of death and bereavement can be strange and mysterious for some. Calhoun et al. (2010) cite Klass and Walter (2001) that observe that the bereaved can be reluctant to talk about such things as belief in paranormal phenomena, continuing bonds, or unpredictable bouts of distress. The role of the clinician is that of a steady and importantly, non-judgmental, listener to all these experiences.

### *Courage to hear*

Sometimes it may be asked of the clinician to listen to unpleasant stories of death, when illness, accident or personal violence has produced gruesome and traumatic images of death that the bereaved persons may carry with them. This requires strength and calm courage and a focus on the pain and shock of the bereaved, rather than on one's own. Often this is the only outlet for the bereaved who may otherwise be carrying the burden of these images alone. Tedeschi and Calhoun (2004) observe that 'quiet sympathy' allows the client to speak of the horrific details as they need to. (p. 55)

### *Appreciation of paradox*

In order to facilitate posttraumatic growth, the clinician must be able to appreciate the two sides, or more, of the stories told by the bereaved. For example: in the vulnerability of grief emerges strength; from doubtful questioning, new insights can emerge; and in the need for support, greater independence can be achieved. Clinicians working with grieving persons must remember that the process by which posttraumatic growth may unfold occurs in the process of grief itself. They remind us that a fundamental concern is the timing of discussions of growth, and the attributions made for the cause of posttraumatic growth. The helping clinician should be sensitive to the readiness of people to consider emerging indications of growth, and how these have come about. They note that some bereaved persons may decide at the outset that they are going to 'make something good come of this' but the vast majority are simply trying to get through their distress in the early phase of their loss. When clinically appropriate the helping clinician can bring indications of change to the attention of the bereaved person as they seem ready to engage in more deliberate conversation about it. The clinician should take care to attribute these changes to the *struggle with* the grief and loss, not to the loss itself.

## Chapter 4

### Narrative Therapy

#### 4.1 Narrative Therapy

Stories or 'narratives' are how people remember and describe their life histories. They are made up of snippets of remembered events and the meanings attached to them, merging into themes, also the themes of how we define ourselves. The plots of our stories describe ourselves and our loved ones as heroes, victims or villains, and inform our identities and colour our expectations of our future.

David Epston and Michael White, the founders of Narrative Therapy, explain how certain events in our life histories are privileged and selected out over other events as more important or true. As the story takes shape, it invites the teller to further select only certain information while ignoring other events so that the same story is continually told. We are the subjective authors of our life stories, and our realities. Thus, our stories both describe and shape our sense of our lives and ourselves (White, 1988; White & Epston, 1990).

The stories of our lives may be inspiring or oppressive, meaningful and beneficial, or filled with limiting beliefs. Stories can become limiting or problematic when they become dominated by problems that work to oppress. They may become, in the words of White problem-saturated (White, 1988; White, 1997). In fact, we start defining ourselves in terms of our problematic stories as, say, depressed or victimised. One of the aims of Narrative Therapy therefore is to 'externalise the problem' – 'the person isn't the problem; the problem is the problem'.

William Madsen (1997) describes how we organise our experiences in the form of stories. These narrative or life stories provide frameworks for ordering and interpreting our experiences in the world. We always have multiple stories available to us and our reduced dominant stories do not adequately capture the broad range of our experience.

In fact, there are always events that fall outside any one story. However, over time particular narratives are drawn upon as an organising framework and become the dominant story. These dominant stories are double-edged swords, sometimes positive, sometimes inflexible, limiting and problem-saturated.

Alice Morgan (2000) elaborates that we all have many stories about our lives and relationships, occurring simultaneously. For example, we have stories about ourselves, our abilities, our struggles, our competencies, our actions, our desires, our relationships, our work, our interests, our conquests, our achievements, our failures. The way we have developed these stories is determined by how we have linked certain events together in a sequence and by the meaning we have attributed to them. The dominant story that a person holds, of say, their success with love, will not only affect the person in the present but will also have implications for future actions. Yet, our lives are multistoried. There are many stories occurring at the same time and different stories can be told about the same events. No single story can be free of ambiguity or contradiction and no single story can encapsulate all the possibilities of life. As Morgan notes at the end of her first chapter: "As I have tried to explain, narrative therapists think in terms of stories – dominant stories and alternative stories; dominant plots and alternative plots; events being linked together over time that have implications for past, present and future actions; stories that are powerfully shaping of lives. Narrative therapists are interested in joining with people to explore the stories they have about their lives and relationships, their effects, their meanings and the context in which they have been formed and authored." (Morgan,2000, p. 10)

"Narratives organize our field of experience, promoting selective attention to particular events and experiences, and selective inattention to other events and experiences. In this way, much of our lived experience goes unstoried, it's obscured and phenomenologically does not exist. Particular narratives can become problematic when they constrain us from noticing or attending to experiences that might otherwise be quite useful to us." (Madsen, 1997, p. 7)

It follows then that the role of the narrative therapist is to explore with the person other stories that are available to them, particularly those that may enhance their sense of self as capable, adaptable and more free from the problem-saturated stories that may underlie current experienced maladies.

Furthermore, Narrative Therapy aims to "...bring forth and thicken' stories that did not support or sustain problems...as people began to inhabit and live out these alternative stories, the results went beyond solving problems. Within new stories, people could live out new selfimages, new possibilities for relationship, and new futures." (White & Epston, 1990, p. 16)

Morgan (2000) elaborates that to be freed from the influence of problematic stories, it is not enough to simply re-author an alternative story. She notes that Narrative therapists are interested in finding ways in which these alternative stories can be 'richly described'. The opposite of a 'thin conclusion' is understood by narrative therapists to be a 'rich description' of lives and relationships. Rich description involves the articulation in fine detail of the story-lines of a person's life, also detail that does not normally make up the main story line of how a person for example would describe their childhood. It is within the detail of our oft abridged and thus reduced stories that we find exceptions, also exceptions to how we may have normally described ourselves as.

Carmel Flaskas views the wellspring of self as "an ongoing everchanging manifestation of potentiality." (Flaskas, 1999, p. 21). In the same vein, Harlene Anderson emphasises the wonderfully flexible nature of the self, saying that it is "always engaged in conversational becoming constructed and reconstructed through continuous interactions, through relationships." (Andersen, 1997, p. 22)



The founding fathers of Narrative Therapy are Australian Michael White, and his friend David Epston from New Zealand. The therapy became mainstream with the publication of their co-authored book *Narrative Means to Therapeutic Ends* in 1990. The book's success was followed by many more publications by White, Epston and other authors. Another significant publication in this field is Michael White's *Maps of Narrative Practice*, published in 2007, a presentation of six kinds of key conversations in therapy. Some other notable writers are Bill O'Hanlon, Lorraine Hedtke, Gerald Monk, Gene Combs and Jill Freedman; Victoria Dickerson and Jeffrey Zimmerman; Sallyanne Roth and Kathy Weingarten in the United States and Stephen Madigan in Canada.

The Dulwich Centre, in Adelaide, Australia, has been the hub of Narrative Therapy since 1983. They are instrumental in the development of narrative ideas and practices and offers extensive worldwide training. Their publishing house has been a mainstay of narrative books and professional journals. The Dulwich Centre Foundation works in close partnership with two other organisations: the Evanston Family Therapy Centre (Jill Freedman and Gene Combs) and the Narrative Therapy Centre of Toronto (Angel Yuen and Ruth Pluznick).

#### **4.2 The Stance and Role of the Narrative Therapist**

White (1995) notes that the role of the narrative therapist is that of collaborator or co-author with the client. Together the stories that give meaning to the client's life are explored. Carr (1998) describes it as follows: "Within a narrative frame, human problems are viewed as arising from and being maintained by oppressive stories which dominate the person's life... Developing therapeutic solutions to problems, within the narrative frame, involve opening space for the authoring of alternative stories, the possibility of which has previously been marginalized by the dominant oppressive narrative that maintain the problem." (p. 468)

In contrast to the objective scrutinising, diagnosing, evaluating and treating of a client, the narrative therapeutic process becomes “a joint performance, characterised by respect, collaboration and negotiation of possible meanings... This approach differs from other therapeutic approaches by aiming to establish a collaborative dialogical occasion that will create the opportunity for self-agency in which the client participates in creating alternative narratives and a preferred way of being.” (Marais, 2006, p. 120)

Harlene Anderson (1997, p. 94), describes this therapeutic stance as a ‘philosophical stance’ as it represents the biases and values that we hold and the way we look at the world, from within the professional as well as the personal life of the therapist. Knowledge, according to her, what we know or think we might know, is linguistically constructed. She stresses that the development and transformation of knowledge is a communal process, and knowledge and the knower are interdependent. Knowledge and language are relational and generative. “Inherent in language, therefore, is the transformation of experience, and at the same time it transforms what we can experience. A transformative view of knowledge and language invites a view of human beings as resilient; it invites an appreciative approach. And, it invites uncertainty.” (Anderson, 1997). If knowledge and language are accepted as relational and generative, then it follows that a collaborative relationship and dialogical conversation are at the heart of therapy. Therapy is a mutual activity in which client and therapist are conversational partners who connect, collaborate and create with each other (Anderson, 1997). This mutual, shared inquiry is shaped and reshaped as the client and therapist struggle with and address the issues at hand. Likewise, she notes, both client and therapist are shaped and reshaped in this process.

In such a therapeutic meeting, a person is challenged to be an active participant in their preferred way of being. White (1997, p.130) emphasises that one-way accounts of therapy contribute only to “thin conclusions about the nature of our practice” and that we then “deny ourselves that which would otherwise be sustaining of us in the therapeutic endeavour”.

Narrative Therapy provides a means to 're-author lives' (Carr, 1998; White 1995) in which the therapist takes the role of a partner or collaborator with the client, rather than an authority figure. (Angel, Dennis & Dumain, 1998). In true postmodern style, the class-distinction between therapist and client falls away. Karl Tomm, in the foreword to White & Epston's book *Narrative Means to Therapeutic Ends* (1990), talks of a more "egalitarian relationship between professional and client" (p. ix). The Narrative Therapy Centre of Toronto calls it a respectful and collaborative approach to counselling where the therapists' role is to collaborate with clients to re-author their lives. Jodi Aman refers to a workshop she attended in 2003 with David Epston, where the concept of the therapist as the host of a cherished guest underlines the lowering of the power differential that underlies the therapeutic relationship (Aman, 2006).

"A more modest professional identity doesn't involve completely separating the professional from personal experiences of life. It could be said that we are interested in taking the modernist notion of the Self down off its pedestal, both for clients and for counsellors. We're not at all interested in creating a professional identity for counsellors that is on a pedestal, that consists of a bounded individual, an heroic prime-mover in the world. Instead, a more modest sense of self might include the notion that I am, as a counsellor, living my own life struggling in the same kind of discursive context as those who consult me. This doesn't mean our experiences are equivalent. We will sometimes occupy different discursive positions and there are notions of professional privilege to consider. What's more, there's an ethical duty to centre in counselling the experience of the person consulting me. But I'm not a super person, and the notion of self isn't as stable as it is made to sound within conventional psychology. Shifts and changes occur and it may be me who seeks out a counsellor next week." (Winslade, 2002, p. 38)

To illustrate this, Alice Morgan gives examples of how a narrative therapist creates this through asking questions such as:

- How is this conversation going for you?
- Should we keep talking about this or would you be more interested in ...?

- Is this interesting to you? Is this what we should spend our time talking about?
- I was wondering if you would be more interested in me asking you some more about this or whether we should focus on X, Y or Z? (Morgan, 2000).

The narrative therapist is a compassionate and committed ally, a collaborator and co-solution finder with the client: "If I were to restrict myself to only one aspect of White's work that I have taken over, it would be that of 'externalizing the problem.' This is summarized by his maxim: 'The person isn't the problem; the problem is the problem.' This provided a rationale and practice to position myself in therapy, that is, to be on everyone's side at the same time and to act with commitment and compassion against the 'problem,' whatever the problem might be. It freed me from the constraints of some of the prevailing practices that I found distanced me from the family and reduced my fervor." (Epston, 1989, p. 26)

In *Narrative Means to Therapeutic Ends*, White & Epston (1990) go as far as resisting the term 'therapy', preferring instead 'therapeutic conversations': "We believe that 'therapy' as a term is inadequate to describe the work discussed here. The Penguin Macquarie Dictionary describes therapy as 'the treatment of disease, disorder, defect etc., as by some remedial or curative process.' In our work we do not construct problems in terms of disease and do not imagine that we do anything that relates to 'a cure'." (p. 14)

### **4.3 Therapeutic Tenets of Narrative Therapy**

To describe a therapeutic stance and some techniques deployed during therapy does not do justice to the miracle that takes place during therapy. The following exposition aims to elucidate some of the main tenets of Narrative Therapy, though it has to be borne in mind that therapy is always unique and that it takes place in a space that is created by a therapist and client working bravely together to conquer, reframe and grow through a process of discovering of hidden potentialities and new ways of being.

Problem stories affect people's identities and generate blame and hopeless feelings. Problems persist because problem-saturated stories persist. Thoughts and experiences of others and oneself become the interpreting and validating lens that fix and perpetuate the problem story. "In a nutshell, a robust, preferred story needs to replace the dominant story which is failing to encapsulate experience, or is unhelpful, unsatisfying, and dead-ended." (White & Epston, 1990, p. 14.)

The Narrative therapeutic process involves externalizing problems, deconstructing old stories, and re-authoring new stories by implementing well-crafted questions. These questions open up space to create alternate stories. The aim of therapy, according to White, is the "identification or generation of alternate stories that enable them [the clients] to perform new meanings, bringing them desired possibilities." (White & Epston, 1990, p. 15.)

#### **4.3.1 Deconstructing**

A therapist asks questions to deconstruct the problem story, detail it, explore its context, and to reveal the dominant social, cultural and political practices that have helped create and maintain the problem. Some therapists refer to the deconstructing process as unpacking.

#### **4.3.2 Externalising of the Problem**

Michael White, who has probably done more than any other single person in developing the concepts and practices of Narrative psychotherapy, is known for developing the concept of 'externalisation of the problem'. "In his view, knowledges and stories that a person carries around may impoverish their lives or subjugate them. Most people who come to therapy come with problem-saturated descriptions of themselves. Helping

people to find alternative stories and descriptions of themselves as capable, competent and even heroic in the face of problems is the task of the therapist.” (Evans, 2003, p. 10)

A therapist asks questions and makes comments that emphasise the problem as an outside influence on the person rather than as a characteristic or defect inside them or their actions. So, for instance, the Narrative therapist would address anger as a concept external to the person, and would aim to separate the identity of the individual from the nature of the problem. In this way, a person may come to experience themselves as separate from the anger, and aim to control the anger rather than anger controlling them. Externalizing talk changes clients’ relationship to problems and shifts the focus on the relationship between the person and the problem instead of a focus on the person as a problem.

Patterson (2008, p. 4) concurs: “The process of expression literally takes deep feelings out of the body, externalizing them so that they become workable. Through this process, grieving clients are able to see that they have some control over their lives, and can tap into their strengths and their inherent wisdom.”

#### **4.3.3 Personifying the Problem**

To aid in externalising of the problem and to help people renegotiate their relationship with it and exercise control over it, the problem is often given a name or personified. White & Epston (1990) believed that labelling the problem facilitated the narrative in such a way that problems became characters of the story. In this way, these problem ‘characters’ could be seen as ‘the bad guys’ in the context of their life. The reciprocal influence of the problem and person can also be more readily evaluated using ‘externalisation’.

#### **4.3.4 Creating 'Thicker' Narratives and Alternative Stories**

Narrative Therapy holds that a person is rich in lived experience, and that only a fraction of this experience is storied and expressed at any one time. This means that a great deal of lived experience inevitably falls outside the dominant stories about the person's life and relationships. Yet, "those aspects of lived experience that fall outside of the dominant story provide a rich and fertile source for the generation, or re-generation, of alternative stories" (White & Epston, 1990, p. 15) - stories that may provide an alternative, vigorous and more robust identity. White calls those aspects that fall outside of the dominant story "unique outcomes". (ibid)

#### **4.3.5 Mapping Influences and Externalising Conversations**

As a person's history is explored in much more depth, influences are identified that may be unnecessarily impacting on the client's self-perception, creating 'problem-saturated stories'. These are also discussed as separate to the client enabling the client to distance himself from it, or reframe his perceptions. The extent of the influence of the problem-saturated story is explored through questions, and how others may view this same story. Further exploration of, for instance, times when this 'problem' did not hold sway over the person is explored. Perhaps a question may be asked such as 'suppose a miracle happened and this ... would not be the case, how would this look?' (Shapiro & Ross, 2002)

#### **4.3.6 Using Questions to Construct a Preferred History**

Questions in Narrative Therapy are intended to generate experience, rather than information. By asking questions that help to externalize and deconstruct the problem, a space is opened in which the problem-saturated story can be seen as only one version of experience. Soon, exceptions to the problematic or limiting story are uncovered. "These questions bring forth information that contradicts the problem-saturated description...

and assists persons in identifying their competence and resourcefulness in the face of adversity.” (White & Epston ,1990, p. 45)

“How had they managed to be effective against the problem in this way? How did this reflect on them as people and on their relationships? What personal and relationship attributes were they relying on in these achievements? Did this success give them any ideas about further steps that they might take to reclaim their lives from the problem? What difference would knowing what they now knew about themselves make to their future relationship with the problem?” (White & Epston ,1990, p. 47)

In time, the person becomes more ready to have a conversation about when ‘the problem’ didn’t exist or when they did something outside the problem-saturated story. “The overarching goal of narrative therapy is to help the patient replace the problem-saturated story by constructing a preferred story.” (Shapiro & Ross, 2002, p. 97)

As the personal narratives ‘thicken’ with the richness of human experience, moments of insight, and favoured outcomes start emerging, referred to as ‘sparkling moments’ or ‘unique outcomes’. Gerald Monk et al. define these in *Narrative Therapy in Practice: The Archaeology of Hope* as a moment in a problem-saturated story when the client demonstrates a surprising achievement in defeating or limiting the influence of the problem in his or her life. Such moments, which are often isolated and neglected, Monk calls ‘the shining stars’ in a sky darkened by the dominance of the problem.

“Patients are often dismissive of these sometimes small and initially uncharacteristic glimmers.... Instead of ignoring such hopeful moments, Dr B chose to focus intently on them. ‘Wait a moment! Are you telling me you’ve been thinking about tackling your diabetes? How did you manage to do that? How did that make you feel? How is that in



line with what you want from your life?’ Lingering over such occurrences, and asking the patient to reflect on their details, helps them grow in importance and power.” (Shapiro & Ross, 2002, p. 97)

#### **4.3.7 Creating an Audience**

One of the most effective ways of strengthening the new, preferred story, is by creating a receptive audience who serve as ‘witnesses’ and provide support. With others cheering the person on, it is so much harder to fall back into old patterns. Significant others, who of course should support the client’s new self-description strengthen the support provided by the Narrative therapist. (Shapiro & Ross, 2002) and (Biggs & Hinton-Bayre, 2008)

#### **4.3.8 Privileged Position**

The client as the teller of their story assumes the ‘privileged position’, in that they become the reader and author of the text of their lives (White & Epston, 1990). As the story is told the therapist compassionately questions the foundation of beliefs and validity of interpretations. The aim is to show exceptions to problems, and helps the client see a new reality: as the interpretation of the past changes, a new future may be envisioned.

#### **4.3.9 Journal Writing**

Journal writing and the writing of letters is often used to thicken narratives, explore the ongoing relationship with a loved one, and gain more clarity and insight. “By committing events, thoughts, beliefs and emotions to paper the client’s ability to see their reality is enhanced. It provides them with insights, connections and ‘bigger-picture’ moments. Depending on the nature of the problem, the writing (but not posting) of letters to those

creating the problems may help to resolve the conflicts and loss of self. Journal writing activity often becomes a between-session activity for the client to continue to retell their story.” (Biggs & Hinton-Bayre, 2008, p. 24)

#### **4.3.10 Literary Guidance**

The emphasis on words throughout the telling of the story and the re-storying of a client’s history is obvious. It is used therefore to great effect to enhance therapy. Note-taking by the Narrative therapist is encouraged, stressing the incorporation of exact patient language, a willingness to share these observations with the patient, and encouragement of the client to take his/her own notes during a session, implying that the patient’s observations are as valid and important as the therapist’s. White has been known to write letters to a client after a session, which combines note-taking and sharing of insights with the client. This is another powerful technique that not only summarises key points but with the advent of e-mail, need not be excessively time-consuming. Documents, such as certificates, awards, and diplomas specifically created to commemorate significant developments during therapy, are also sometimes utilised. (Shapiro & Ross, 2002; White & Epston, 1990)

During therapy, special attention is paid to the use of words, and using words in new ways (such as the term ‘re-membering’ during grief counselling). This attributes new meanings and allows new insights into roles played during life-histories. The client is also encouraged to use different, more expressive, words. (White & Epston, 1990)

#### **4.3.11 Narrative Empathy**

Rather than developing empathy for the client per se, the therapist may strive for narrative empathy. Therapeutic empathy is described as an active narrative process, in which the therapist attempts to construe and express the inner emotional logic of the

client's problem patterns. The aim is to elicit a 'That's me!' response from the client, a self-recognition that makes the client feel truly understood. (Omer, 1997) "Narrative empathy seeks to interpret and express the inner emotional logic of a client's problem patterns." (Biggs & Hinton-Bayre, 2008, p. 25)

What would be considered successful therapy? White & Epston (1990, p. 15) answer thus: "an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing with them desired possibilities – new meanings that persons will experience as more helpful, satisfying and open-ended."

#### **4.4 Enabling Identity Growth**

Karl Tomm, in the forward to *Narrative Means to Therapeutic Ends* (White & Epston, 1990) write 'our personal identities are constituted by what we 'know' about ourselves and how we describe ourselves as persons. But what we know about ourselves is defined, for the most part, by the cultural practices (of describing, labelling, classifying, evaluating, segregating, excluding, etc.) in which we are embedded" (p. iix)

Lorraine Hedkte (2010) elaborates on the postmodern version of the self. This self is largely defined through relationship. The postmodern self is constructed through language and discourse. Each self is made up of multiple selves, which are nuanced by subtle differences of context and of linguistic content.

Our stories and identities are not fixed in one linear reality, but exist in a vibrant dialogical form (Bakhtin 1981). The term 'dialogical' here refers to the ongoing energy generated from people's words to each other in an endless stream that is never finalized (Bakhtin, 1981). It is in dialogue or conversation that our identities are shaped and reshaped, countless times, through story. As Gergen (1999) notes, there are "...no independent selves; we are each constituted by others (who are themselves similarly

constituted). We are already related by virtue of shared constitutions of the self.” (pp. 11-12)

‘Thin’ descriptions of our histories and the roles we played, often lead to thin conclusions about a person’s identity, leading to many negative consequences (Morgan, 2000). These limiting conclusions are expressed as a truth about the person who is struggling with the problem and their identity. Consequently, the person with the problem may be understood to be ‘bad’, ‘hopeless’, or ‘a troublemaker’. These thin conclusions, drawn from problem-saturated stories, disempower people as they are regularly based in terms of weaknesses, disabilities, dysfunctions or inadequacies. (Morgan, 2000)

Once thin conclusions take hold, people naturally tend to gather evidence to support these dominant problem-saturated stories. Consequently, the influences of these problematic stories become more and more powerful. In the process, times when the person has escaped the effects of the problem, and times when they have not been living up to their negative labels, become less visible. These stories of course do not happen in a vacuum, but are upheld and reinforced by family members, loved ones, friends, teachers, and so on.

Narrative therapists are interested in conversations that seek out alternative stories, they are intend on re-storying, and re-membling, thus they will actively seek out stories in the memory of the person of alternative identity traits that will assist him or her to break from the influence of the problems they are facing. Just as various thin descriptions and conclusions can support and sustain problems, alternative stories can reduce the influence of problems and create new possibilities for living, and new identities. Therefore, a person is encouraged in Narrative Therapy to actively seek out and re-author new and preferred stories for their lives and relationships. (White, 2007)

When preferred stories arise during therapeutic conversations, Biggs and Hinton-Bayre (2008) note that the 'beginnings of self-redefinition' takes place as a person reorients themselves contextually. During bereavement therapy with an interest in identity growth, rather than eliciting a singular story of loss, we might seek out multiple stories of relational change.

Re-authoring involves re-envisioning both the past and the future. It also requires making the invisible constraining problem-supporting discourses visible and helping a person to confront the discourses that oppress or limit them as they pursue their preferred directions in life (Freedman & Combs, 2000). The new or alternative story is sometimes called a preferred outcome, and it is this new story that becomes the vehicle for a new self-identity.

#### **4.5 Some Notes on the Changes in Psychology, and where Narrative Therapy fits**

Psychology has seen so called 'waves' since its inception in Western society. These 'stages' in psychological thinking occur within and is spawned from the zeitgeist it develops within.

The first wave, Psychodynamic, began with Sigmund Freud's Psychoanalysis, which has been expanded through the theories of Ego Psychology, Interpersonal Psychology, Object Relations, and Self Psychology. Freud himself was profoundly pessimistic about human nature, which he felt was governed by deep, shadowy drives that we could only tenuously control. (Lambert, 2007)

The second wave, Behavioural, was championed by B. F. Skinner and others, and later expanded to also give rise to Cognitive Psychology. From this view techniques are deployed to modify behaviour and/or belief, so as to modify affect. Cognitive Behaviour

Therapy is a structured, short-term, present-oriented psychotherapy, directed toward solving current problems by modifying distorted thinking and behaviour. It rests on the supposition that distorted thinking (which influences an individual's mood and behaviour) is common to all psychological disturbances. The model of human life in the behaviourist tradition seemed to many, the writer included, too mechanistic, humans were fairly passive beings mercilessly shaped by the stimuli and the contingent rewards and punishments that surrounded them. (Lambert, 2007)

The third wave, Humanistic, spearheaded by Carl Rogers, holds a much more tender view of the human condition through unconditional positive regard and recognition of meaning and value (and sometime spirituality) as experienced by the individual. Third wave approaches such as Narrative Therapy, Phenomenology, Collaborative Language Systems, Positive Psychology, Solution-Focused Brief Therapy and Steven Hayes' Acceptance and Commitment Therapy (ACT) draw their inspiration from diverse sources in psychology, linguistics and philosophy (such as Existentialism) that have, since the 1950s, articulated new ways of considering how people make sense of themselves and construct the world they live in as meaningful.

The field's roots go back at least to 1962, notes Lambert (2007), when Brandeis psychologist Abraham Maslow wrote about what a human life could be at its greatest in *Toward a Psychology of Being*. His 'humanistic psychology' became the discipline's 'third force', following psychoanalysis and behaviourism. (Lambert, 2007). According to Biggs & Hinton-Bayre (2008) Narrative Therapy falls within the broader third stream of psychology.

Third wave models keep many of the techniques from the first two waves but focus more on contextual behaviour than atomistic behaviour, flexible skills than pathology, and function than form. Cloud (2006) notes that third wave methods emphasise the broad constructs of values, spirituality, relationships and mindfulness.

A fourth wave has been proposed, Transpersonal Psychology, drawing upon the writings of Karl Jung, Roberto Assagioli, Ken Wilbur, Charles Tart, Stan Grof, Kenneth Pelletier, and Charles Garfield, among others (Boyd, 2003). This much more mystic stream is concerned with transpersonal, transcendent and spiritual aspects of the human experience.

According to O'Hanlon (1994) Narrative Therapy is part of the fourth wave, an expression of postmodern thinking. The emphasis of therapy is not to eradicate 'errors in thinking' but to "believe.... that people are not their problems and that their difficulties are social and personal constructions" (O'Hanlon, 1994, p. 28). Evans (2009) concurs and describes the role of the therapist as such: "There has also been a subtle shift with respect to the role of the change agent. In the early model, the change agent is external to the system, and someone who acts upon the system. The later views include a view of inclusiveness and reciprocity, the notion of 'being with' rather than 'doing to' and the notion that the therapist and the patient/client are together a part of a greater whole. On the way to complexity and emerging from systems approaches, is the fourth wave which comprises various constructivist influenced therapies, principally Narrative and Solution Focused therapies." (Evans, 2003, p. 9) And also: "Solution focused and narrative psychotherapies reflect a radical shift in thinking, away from a pathologizing view of the person to a competency and strength based view." (ibid)

It seems that the so-called 'waves' are streams of thinking based on a particular view of what it is to be human, that, especially when it comes to third, fourth or even fifth waves are not easily categorisable in terms of therapeutic models belonging to it. Perhaps this is because we are still in the midst of the new thinking in Psychology, and it is always easier to describe a stream of thought in hindsight. In the writer's own opinion, Narrative Therapy best belongs in the broad group of third wave therapeutic models.

Importantly, it has to be noted that Narrative Therapy developed and develops within the broader cadre of society and will of necessity reflect streams found in post-modernistic and social constructionist thinking.

“Narrative therapy is, alternatively, informed by poststructuralist ideas. Post structuralism refers to a movement away from the idea that there are deep or real structures in people; e.g. a real self, a true self, which can be discovered by experts. This outlook resists the search for essential truths about people and questions notions of therapist ‘objectivity’ and ‘expertise’ in therapeutic work.” (Hilker, 2005, p. 4)

What is important to note is the much more democratic style of therapy, and a move away from a schismatic, reductionist and dare I say disrespectful view of the clients we engage with. In fact, third wave therapeutic models (and beyond) sees the therapeutic exchange as one in which meaning is co-created, and healing takes place in the therapeutic relationship which is marked by kindness, recognition, patience and human contact.

#### **4.6 Narrative Therapy: A Postmodern Therapeutic Model**

Postmodernism refers to a family of concepts that critically challenge the certainty of objective truths, the relevance of universal or meta-narratives, and language as representative of the truth.

According to Hedtke (2010) Jean-Francois Lyotard (1984) has been widely credited with popularising the critique of modernism and promulgating the term ‘postmodern’. He described a paradigm shift in thinking that began in the late nineteenth century. According to Lyotard the human sciences were instruments of social control and had proven themselves unworthy and false in regulating or explaining social practices. In fact, postmodernism holds a distinctly critical view of modernist thinking that held



objective truths and sharp classifications at its core. From the viewpoint of postmodernism, what seems to be realities are only social constructs, as they are inherently subject to change according to time and place. In fact, it holds realities as plural and relative, dependent on who the interested parties are and what their interests consist in. Postmodernism is critical of what is seen as modernist overconfidence by so called experts, and can even be seen as a reaction to the stance of the dominant voices in modernity. Some of the most influential postmodern thinkers are Martin Heidegger; Thomas Samuel Kuhn; Jacques Derrida; Michel Foucault; Jean-Francois Lyotard; Richard Rorty; Jean Baudrillard and Fredric Jameson.

For Heidegger, there is no intrinsic distinction between phenomena or things and how they appear to us. He criticises thinking that divides subject and object. In his book *Being and Time* which was written in 1927, Heidegger describes how human beings are absorbed in the world, inextricably responsive to it, concerned with it, since fundamentally our being is an opening onto existence (Heidegger, 2008). We are not complete sealed-off subjects separated from an outside by the skin of our bodies. Each human existence essentially is interaction with the world and with other people. Heidegger's name for this communal dimension of my own Being-in-the-world is 'Being-with'. Being-in-the-world, and the openness to the process of *Dasein's/Being's* becoming was to bridge the perceived gap between these two. (Madison, 2005). This division is implicit in Rationalism, Empiricism and Methodological Naturalism and is seen reflected in many first and second wave psychological theories. Derrida points to the implicit circularity between premises and conclusions, origins and manifestations, which seems to correlate well with Narrative therapy's tenet that our (his)stories and the conclusions drawn from them are subjectively and reflexively influenced. Richard Rorty argues in his book *Philosophy and the Mirror of Nature* published in 1979 that contemporary Analytic philosophy mistakenly imitates scientific methods. He criticises traditional epistemological perspectives (such as Representationalism) that rely upon the independence of knowers and observers from phenomena and the passivity of natural phenomena in relation to consciousness. Rorty argued that philosophers since the 17<sup>th</sup> century developed an unhealthy obsession with the notion of representation: comparing

the mind to a mirror that reflects reality. This, as one can see, is analogous to Narrative Therapy's co-creation of meaning by therapist and client.

Michael White in particular draws on the theories of Michel Foucault, particularly as it pertains to the externalisation of the problem, which aids clients in acknowledging that there may be more than one 'truth', not just those they held 'true' before that served only to subjugate them. The provision of the opportunity of alternative, previously neglected stories, is central to the therapeutic endeavour and ultimately leads to relief as well as a change in how clients experience themselves and their efficacy. (White & Epston, 1990)

Postmodern psychology resists objectification of phenomena and independence of observers and views ideas, instead, as social and personal constructions. "I think at its best (in a more moderate stance) postmodernism is a more systematic way to practice intellectual humility, to bring attention to the limits of certain kinds of thinking, and thereby counter certain absolutist claims of extremists and dogmatists in all fields. This philosophy allows for a challenging of the tendencies to rely on the authority of what has already been created--what Moreno called the 'cultural conserve', and to dare to engage in the act of creativity - and its associated activity, creative mythmaking." (Blatner, 2002, p. 2)

Postmodern therapies therefore take a non-pathological, non-judgmental view, and appreciate, and in fact respects and utilises the client's reality and uniqueness. It is collaborative in structure and process. These therapies typically make use of story and narrative metaphors. (Anderson, 1997)

When it comes to postmodern grief therapy, the aim is therefore to engage in meaning making in the interaction between therapist and distressed person, rather than viewing

personal history as an objective recording of events examined and worked on by a so-called expert. In Postmodernism, as in Narrative therapy, there is no one objective 'truth', rather, there are multiple possible interpretations of any event, and many more that may be recalled. Within a narrative approach, our lives are seen as multi-storied rather than single-storied.

#### **4.7 A Few Tenets of Postmodernism that has Particular Reference to this Study**

*Discourse:* by its very nature verbal conversation is the main mode of communication in psychotherapy, and by all means in Narrative Therapy. The richness of this interaction is where stories are related and therapy takes place.

*Narrative:* a narrative is naturally a story, a description of remembered events, which may be presented in various formats (also often used in Narrative Therapy) such as an orally related (his)story, a written series of events, a letter, a poem or a song. Humans have told stories probably for as long as language has existed, it is an essential expression of being human and much of our social constructions are expressed this way (think, for instance, of an advertisement on television). Narrative Therapy holds that our identities are shaped by the multitude of stories we embrace such as conversations that took place with important people in our lives. In Narrative Therapy stories that are problematic to the client are externalised so that they can be infused with new and richer meanings.

Blatner (2002) suggests that in modernity, much was spoken of as dry fact, and there was a kind of denial of the idea that facts did not in fact stand alone, but were pulled out selectively to support this or that general interpretation, this or that story, which in turn tended to support certain beliefs and the established status of certain groups. Individuals, groups and nations all have their selected histories, the stories which tend to justify or create a coherent meaning for their existence. In this process, elements that don't fit are often ignored or actively repressed. Blatner notes that narratives could and

have fostered the marginalization of those sub-groups or issues that suggest a different interpretation. He uses the example where the cowboys were the good guys and the Indians the bad guys in the modern, mid- 20th Century, depending on who tells the story.

*Meta-narrative*: This term recognizes that sets of beliefs and stories are often embedded in even more fundamental sets of beliefs and stories. The histories of some group, for example their pioneering efforts, might be set within a broader frame of the belief in progress, exploration, or even for instance the superiority of Christian culture over 'heathen' indigenous culture. (Blatner, 2002)

#### **4.8 Narrative Therapy in the Context of Social Constructivism**

"A *self* does not amount to much, but no self is an island; each exists in a fabric of relations that is now more complex and mobile than ever before...even before he is born, if only by virtue of the name he is given, the human child is already positioned as the referent in the story recounted by those around him, in relation to which he will inevitably chart his course." (Lyotard, 1984, p. 15).

We are born into the dominant narratives or discourses of our unique cultures that are created by the culture's power brokers. These dominant discourses, or truths, influence local and personal narratives, affect the words we use and the knowledge we have, and become internalised truths. The lived experience of the person becomes lost or subjugated to the dominant narratives (Anderson, 1997).

According to Hedtke (2010) the field of Narrative Therapy has its philosophical roots in the theories of social constructionism. Social construction, a particular postmodern theory, places emphasis on truth, reality, and knowledge as socially embedded and emphasises the role that language plays in the creation of these products. According to the foremost proponent of social constructionism, social psychologist Kenneth Gergen, it

is "...principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live" (1985, p. 266). Lynn Hoffman (2002) notes that the social constructivist stance means that the emphasis has moved from the individual, or the family, to the situation. Problems are not believed to reside within the person, the family, or the larger system. Instead, problems are considered as linguistic constructions, with various punctuations such as the local dialogical context and process of people's everyday lives and the subjugating and oppressing influence of dominant universal narratives. (Anderson, 1997)

French social philosopher, Michel Foucault, whose ideas influenced the thinking of especially Michael White, was committed to calling attention to and challenging the taken-for-granted and often invisible but pervasively influential social, political and cultural institutional structures and practices in which people live. Foucault, persuaded by his studies of institutions such as justice-penal systems and medical-psychiatric systems, believed that the dominant discourses of these institutions gave power and influence to some people, usually to those deemed to have expert knowledge, and objectified, marginalized, or victimized others. (ibid)

As a postmodern theory, much of the practice has been guided by new ideas about the self, relationships, identity, memory, power, knowledge, language, and story. Hedtke (2010) notes that Narrative Therapy provides counsellors with a means to use the premises of social constructionism in conversations that construct changes in peoples' lives. It is based on the premise that people live their lives by stories and that these stories are constitutive of their lives.

According to White, (1991), "The narrative metaphor proposes that persons live their lives by stories-that these stories are shaping of life, and that they have real, not imagined, effects- and that these stories provide the structure of life." (p. 28)

“...a narrative perspective emphasizes that we are beings who harbor multiple stories. The world of stories is alive with possibility, flexibility and multiplicity. Stories not only have meanings that are constructed by individuals. They also contain echoes from communal and cultural histories. And they are maps that lay out future trajectories in life.” (Hedtke, 2010, p. 20). Thus, the focus is on the stories of people’s lives as they are manufactured in social, cultural and political contexts.

Our stories are impacted by ‘cultural discourses’ which shape us also by the schemas of others in our world. Gerald Monk (1997, p. 27) writes “The newly born child is instantly born into a ‘cultural soup.’ From a narrative perspective, problems may be seen as floating in this soup.”

The ‘cultural soup’ is made up of many voices – the dominant culture of our world, our parents, grandparents, teachers, the media all impact on the shaping of our stories, what we hold as important, how we respond to grief, and how we experience our identity in the context of others. From the narrative perspective, dominant cultural discourses and institutions influence the problem stories that people bring to therapy.

White & Epston (1990 p. 14) note “the person’s experience is problematic to him because he is being situated in stories that others have about him and his relationships, and that these stories are dominant to the extent that they allow insufficient space for the performance of the person’s preferred stories. Or we would assume that the person is actively participating in the performance of stories that she finds unhelpful, unsatisfying, and dead-ended, and that these stories do not sufficiently encapsulate the person’s lived experience or are very significantly contradicted by important aspects of the person’s lived experience.”

Andersen (n.d.) describes some basic premises underlying postmodern social constructivism:

1. The concept of objective discoverable knowledge and universal absolute truths is viewed sceptically.
2. The world, our truths, is not out there waiting to be discovered.
3. Knowledge and social realities are linguistically and communally constructed; reality, therefore is a multiverse.
4. Language is the vehicle through which people know and attribute meaning to their world, including realities about the people, events, and experiences of their lives. Neither problems nor solutions exist within a person or a family - they take shape and have meaning within a relational and dialogical context.
5. The goal of therapy is to create a relational and dialogical context for transformation.
6. Transformation - outcomes and solutions - is inherent and emerges in dialogue.
7. Transformation is unique to the client and the participants in the therapy conversation and therefore cannot be predetermined ahead of time.
8. The person and self, including development and human agency, are viewed as interdependent, communal, and dialogic entities and processes rather than as isolated autonomous interior ones.
9. People have multiple identities and their identities are shaped and reshaped in social interaction.

## Chapter 5

### John's Story: A Crushing Suicide

#### *The Cord*

*We are connected, my child and I,  
by an invisible cord not seen by the eye*

*It's not like the cord that connects us 'til birth,  
This cord can't be seen by any on earth*

*This cord does its work right from the start  
It binds us together, attached to my heart*

*I know that it's there, though no one can see  
The invisible cord from my child to me*

*The strength of this cord is hard to describe  
It can't be destroyed, it can't be denied*

*It's stronger than any cord man could create  
it withstands the test, can hold any weight*

*And though you are gone, though you're not here with me  
The cord is still there, but no one can see*

*It pulls at my heart, I am bruised, I am sore  
But this cord is my lifeline as never before*

(Author Unknown)

#### **5.1 Personal Data**

Participant:	John
Age:	Mid forties
Field of Occupation:	Building industry
Education Level:	Senior certificate
Therapeutic Setting:	Psychology private practice
Language:	English



\* In the final report names and some identifying particulars were changed in order to protect the identity of the participant.

## 5.2 Introduction

It all started with a letter. John's son, Luke, had left a suicide note on the dining room table:

*'Within myself I feel empty and dark. I cannot find happiness. I see the hurt and pain I have caused my family, and this pushes me further from myself.'*

Words to tear a parent's heart out. Emma rang the Police and then tried to get a hold of Luke, but to no avail. The Police searched his room and his parents were not allowed to go in there, in case evidence would be disturbed.

*"We still hoped, but deep down we knew... That night some Police men came to our home to tell us the terrible news. It was terrible...like a blur. Emma was inconsolable. I cried all the time. Then it was a revolving door of people all the time that was actually helpful, and tiring. Everyone was so supportive, work was so supportive."*

Luke had left a note in the car too, that he didn't want to be a burden, and his name and address.

Later, another letter was discovered, a letter of wishes on his bed.

The final paragraph reading:

*'To my mom and dad, the two people I love most on this earth. I am sorry, I couldn't bear to fight any longer, we have suffered through so much together and I am sorry I wasn't strong enough. I love you more than anything.'*

Some favourite possessions were bequeathed to his close friends, and the wish expressed to be cremated and a final song to be played 'The Song of Ronan', a song about a little boy who had died of cancer, written from words from the boy's mother's

blog by singer-songwriter Taylor Swift, and all proceeds from the song go to fight cancer. The choice of song and what it represents seemed to foretell a story yet to play out in his father's life. Needless to say, I felt compelled to buy the song and play it too; in tribute to an older boy I only got to know through the eyes of his father.

### **5.3 Mapping Influences**

John's son Luke had committed suicide at the age of eighteen, just after "*a really good*" Easter when Luke went camping with his friends. Luke had some personal struggles with his health, career options and a girlfriend, but nothing that an older and more mature person would deem enough to end his life prematurely for.

I met John a month shy of the first anniversary of his son's suicide. He had been "*fine*", taking care of his wife and making sure she was okay. As she recovered, he suddenly found himself crashing into despair and grief. For almost a year he had been the brave one, not allowing himself to fully feel the pain of the loss. He couldn't do this forever.

John's work entailed overseeing the safety of building contractors for a large company. John's wife Emma is a registered nurse in a responsible position. They have been married for more than two decades and the way John spoke about her implied mutual respect and friendship.

### **5.4 Thickening the Narratives**

#### **5.4.1 The Loss**

On an autumn Wednesday in April, Luke waited until his parents were at work, and invited one of his friends over. He showed her some renovations he did with his Dad, and chatted with her normally. After she left, Luke cleaned up his room and meticulously set out some belongings on his bed, with a letter of wishes. On the dining room table he

left a suicide note that his parents would find first when they came home from work. When John tried calling him around midday, Luke messaged him that his phone's battery was flat and he couldn't talk. Then Luke drove into the countryside and straight into a stobie pole (a concrete post). Later his parents learned that Luke had researched exactly how to commit suicide by driving into a post, at what speed and angle. In the car was another, shorter letter:

*'I welcome Death, I have seen my final sunset. I love my family. Goodbye everyone, I'm in a better place.'*

He also noted his address and in large letters the words *'Do not revive'*.

An elderly couple was first on the scene and called an ambulance. John remembers what the paramedics told them:

*"They put an airway in, but there was no sense of life. He had a weak and rapid pulse for a while. The man explained to us later that he didn't suffer."*

John was touched by the kindness of strangers. They received a card the Sunday after the suicide from the couple who was first on the scene, and later met with them to discuss what they experienced. He teared up when he told me:

*"The man held Luke's hand in the ambulance. He said he didn't wake up at all, he didn't look like he suffered. They were kind to Luke in his last minutes..."*

Because it was an unnatural death, a post-mortem was held and John and Emma only received his body a few days after the accident. A service was held for Luke the following Friday.

*"So many people sent cards and flowers. Emma was too upset to read them, so I read them and took all the phone calls and spoke to family and friends. I tried to shield her, she was just too upset."*

The violent way that Luke died plagued Emma, who was distressed worrying that her son had suffered. As an experienced nurse she knew that Luke in all likelihood died on impact, even though he had a pulse for a while. Despite her belief that Luke likely didn't consciously perceive his pain, as a mother, his suffering upset her greatly. In the beginning, John was calmer, and was Emma's rock. While she was in shock and cried incessantly, John remained stoic and comforted her.

*"She asked me 'why are you not crying?' when she couldn't get out of bed and couldn't function. I just felt helpless to help her. I couldn't help her. She would sit and cry uncontrollably, and I would just hold her hand. She used to get upset: 'don't just sit and watch me crying, cuddle me!'"*

*"But sometimes it was too much for me, I didn't know what to do, so I would see her sitting in her chair looking sad or crying but I'd pretend I didn't notice and walk past her. I felt I couldn't make it better for her."*

Being strong for Emma helped John through the first phase of grief as he didn't have to face his own thoughts and pain and only focussed on comforting his wife. When the couple had counselling together through John's work's Employee Assistance Programme, most of the focus was on helping Emma cope. It was only when Emma started feeling better that John realised how upset he himself was, and sought help, and we had our first therapeutic conversation.

#### **5.4.2 The Loss of the Son**

Losing a child must be one the most difficult challenges of life, many describe it as a lifelong journey of continuing with life's tasks in the company of the deepest grief imaginable. Somehow most parents find a way to keep going, but life can never be the same, and neither can the parent. To lose your son might be akin to losing your parents – a state we have a word for – you become an orphan. To lose your spouse means you

become a widow or widower. There's no English word that I know of for the state of losing your child. Perhaps it is beyond words. But it is interesting that there is no validated social construct for being a parent who once had a child. Perhaps it is only because so many children died in times gone by. In a sense though it may seem as if society negates the severity of such a loss by not recognising how much it changes the status and identity of a parent whose child had died.

In years gone by it wasn't unusual for children to die from infectious diseases and the like. That by no means implies that parents then didn't feel the deep loss of a child that could never be replaced. When the death of children is so common that most families suffered it at some point, perhaps a specific term for grieving parents wasn't necessary. But things have changed now. Because of modern medicine and advances in hygiene standards and nutrition, today in the Western world, most children outlive their parents. Losing a child feels somehow wrong or unnatural.

Our first task was to help John *deconstruct or unpack* the many feelings he held so tightly in check to support his wife. I particularly encouraged him to fully express the emotions he felt were shocking, such as anger at Luke. '*Thickening the narratives*' means allowing John an opportunity to explore his grief in depth and breadth, not just answer, as one does to the question of how you are, with a quick 'I'm fine thank you.' Many people feel uncomfortable in the presence of a grieving person, not knowing what to say or do. Oftentimes, the bereaved try not to burden others with the heaviness of their emotions, or don't know themselves how to express what they are feeling. For John in particular, the focus was on keeping his wife and the mother of his son emotionally comforted, so that his own feelings were probably not thoroughly explored.

As our conversations continued, I found I had to remind John often to explore and express what *he* feels, and not just what Luke might have felt or Emma does. John said

at the start of our third therapeutic conversation that took place just after the one year anniversary of Luke's passing.

*"It's not fair. I'm putting on a brave face, but it's just too much."*

His terrible hurt was expressed in these words:

*"I feel like I'm living somebody else's life. I feel empty. My heart feels dead, dark and empty."*

I encouraged him to tell me more, to really try and help me understand what it's like to be in his shoes:

*"I'm just sad... Luke died. My son died. I'm sad that Luke died."*

John tried hard to maintain his composure, his big eyes staring at the floor in front of him.

*"I'm biting my fingernails again. And... I feel like having a drink again. It's all just too hard."*

Many years before John was a drinker. Giving it up took tremendous determination and it was a turning point in his life.

I encouraged John to stay with his feelings, even when it is so hard. I wanted to show him that I'll be his ally in his pain, and even more, that acknowledging the pain won't kill him. But it was exceedingly hard for this man who always tried to be the pillar of strength for others.

*"I'm okay at work, when I'm busy. But it's hard to be alone. On Thursday it was twelve months. Luke's friends wanted to see the site of the crash, so I went there with them. Emma avoids it, she can't go there. I hate crying, I get clogged up..."*  
he said through his tears.

I tried to stay quiet, to gently urge him to continue.

*"I forget he's away. Then I remember... Emma is getting better now..."*

*“Sometimes I get physically sick, like I want to vomit. Like when I look at his photos and he’s not here anymore.”*

It was only in later conversations that John could express other feelings about Luke and his suicide. For now, he just needed to be with the sadness and feel bereft. It’s okay not to always be the strong one, I told John. And it’s okay to be sad, it seemed to me a very natural reaction, I pointed out.

I asked John who supported *him*?

*“Emma does, and my mother in law and nieces and nephews. We are closer now, Luke’s death has brought us closer. And six or eight close friends. Everyone gets a hug now Luke’s died. Sometimes I go to the kitchen where Emma is busy and just ask for a cuddle.”*

Does it help? I ask. John admits it does:

*“It’s easier than words, it’s easier than talking. It’s just support, yes, it helps.”*

John had been working hard and going to bed late. Furthermore, though as a family they have tried to eat healthily, John finds he looks for comfort in junk food. Sleep and appetite are often affected in times of grief, but without physical resilience emotional resilience is difficult, and I encourage John to take good care of himself and lean on the support of loved ones as much as he needs to, to which he agrees.

John told me about a dream wherein his bag got stolen and he saw kids rummaging through it. He explained:

*“In my bag is my life, everything – my wallet, cards, keys, access to everything I own.”*

We discuss how that may be an expression of everything he had lost, that was turned upside down and felt out of his hands. Also, John experienced his privacy invaded;

suddenly his private life was 'rummaged through' by everyone. He remembered how vulnerable he had felt, trying not to carry "*his heart on his sleeve*", for instance when he did Luke's eulogy.

One can so easily stay with the horrific way Luke died, as Emma did, or become stuck on the why's and how could he's as John did. Cottor & Cottor (1999) note that the narratives that are told over and over by the bereaved, inform the relationship they have with their deceased loved one.

'If our stories are stronger than our biology, then the narrative themes and plots play forth often whether we are present or not. As we choose the stories we want to tell, we produce different nuances and strengths for our relationships to develop over the years.'  
(p. 165)

*"Did God take Luke away for something we had done?"*

John asked me, not really expecting an answer. Questions plagued John all day, as he worked and as he made his way to and from work. I remind him of Luke's words in his note:

*'I don't expect anyone to understand, but I want everyone know this was the right thing for me to do. I do not blame anyone for this, nor should you blame yourselves. I love all of my family and friends with my whole heart. As I spend my final time on earth, I remember all of the good times, all of the experiences and joy I once felt.'*

For the first five therapeutic conversations, John expressed his struggle with trying to understand Luke's thoughts in the days before he passed. John brooded over Luke's feelings and motivations, and he was plagued by incomprehension:

*"How could he do this to me and his mother? He said he did it for us, but I think he was selfish, self-centred."*



I agree with John that Luke was probably quite wrapped up in his own thoughts and did not manage to see clearly how his suicide would affect his parents. John felt compelled to repeat Luke's last days over and over, hoping to find a morsel, an inkling, of what had pushed him to go so far. He couldn't find anything that pointed to such a drastic move. Over and over John's thoughts turned to those few days.

Calhoun et al. (2010) note that death that brings great anguish, especially those losses that are not aligned to the assumptive beliefs of the bereaved, such as that a natural death occurs at the end of a long life and that children or young people shouldn't die, bring the greatest distress but also the greatest opportunity for growth. The shattered assumptions require attention to the rebuilding of assumptions about how the world works. They note that "rumination plays an important part in the attempts to repair or reconstruct a workable belief system in the aftermath of death" (p. 133) and can eventually help to move the person to find more meaning in their own lives. "Ideally, the frequency and disruptive impact of the intrusive thoughts will decrease as the deliberate rumination provides a reconstructed world view and allows the individual to find meaning in the death experience." (p. 133)

In all the bereaved people I've worked with, this held most true for John. Many times over he would repeat words like:

*"I keep getting stuck on the plan, did he plan it? Was he in pain or was he at peace? Was he upset with us? When did he write the letters?"*

I ask about the emotions, also those he didn't feel free to express freely in front of others. John admitted to feeling confused and angry and struggling to understand and accept it.

John pondered incessantly about the “why”, as he put it. These thoughts went over and over in his mind as he tried to make sense of what from his perspective did not make sense to him:

*“I don’t understand how Luke could think that taking himself off this earth will be a better option than working through his problems. He only saw the problems, not the solutions. If he just stood back and looked...”*

John’s ongoing ruminations about why Luke did what he did were often expressed in letters he wrote to Luke, as it was in our conversations:

*“Luke I still struggle with the why of the whole thing. You seemed better, you had great friends and family (my opinion), you went out with friends, you helped me with the verandas. That night you were only a wall away from us. Anyway, that is water under the bridge. I do forgive you for that.”*

“Narratives are stories. People make sense of their lives by telling a story that makes sense of their past and present experiences. Whether they are aware of it or not, people have an autobiography that they are constantly revising in light of new experiences. If something like an important death does not make sense, it is ‘nonsense.’” (Klass, 1996, p. 5) A struggle with a narrative that does not make sense to a grieving father can keep him stuck in thoughts that go round and round, in the hope that if he keeps thinking about it, clarity would eventually come, and ‘the story would make sense’. Eventually, either the narrative would have to make sense somehow, or acceptance has to happen, before the incessant repetitive thoughts would flow and the resultant emotions would shift.

For John, a bit of both happened: he understood better just how hard it must have been for his son and that Luke truly, from his perspective, saw suicide as the only way out of the pain; and of even more significance, John accepted that he would probably never quite know what went through his son’s mind in the days leading up to his death.

It was about our sixth therapeutic conversation when John reported that he started to feel a bit better. He showed insight and growth when he said:

*“I’ve been making a conscious effort to go to bed earlier, and I’m taking some supplements. Then I feel guilty about feeling better. I realise now that not forgiving Luke for the things he didn’t do, made me feel depressed. I was also trying to understand what his plans were, how long he had been thinking about it.”*

As John slowly changed and accepted, he could forgive his son – for what he did, but also for what he neglected to do – a concept he particularly struggled with. John could finally accept that he simply would never quite understand *“what went through Luke’s mind in the days leading up to his suicide.”* These questions had plagued him for a full year:

*“Why didn’t he ask for help? Why didn’t he come to me? Was he planning this all along but pretended he was okay? Or did he make up his mind just the day before? What made him think this was the only solution?”*

For a logical problem solver like John, these thoughts kept him stuck in a pattern of disbelief, non-acceptance and frustration, even anger towards Luke. How could he, *“who had his whole life ahead of him”*, do something like this? Despite accepting to some degree that he would never fully understand, John found himself tripping back to questioning very easily. Acceptance of a son’s suicide is always only partial, I imagine. John could simply not fathom how Luke could not see other solutions to his problems. We talked about this in many of our conversations. One of the thoughts that eventually helped his incessant questioning to ease was when John and I had a laugh about our children sometimes doing ‘silly things’ because they think they’re all grown up, but really they are still very immature. He remembered that when he himself was young he had thoughts about life he was quite certain about, that he later realised were not quite accurate. He could finally forgive Luke because he knew:

*"It was a young and stupid and impulsive thing to do, he was just young and stupid..."*

His words on another occasion reflected John's softened attitude further:

*"He was just human you know, just a boy that sometimes was silly. I'm upset that he never gave himself the chance to grow up and think in a better way. But I also understand now, the more I think about it, that Luke was just too immature to realise, to know what he did was not the best solution."*

*"If he were older I would have had more trouble with it. But because he was young and vulnerable and silly I can forgive him."*

Klass (1996, p. 5) notes that "Both individuals and societies want to keep seeing the world the same way, but sometimes death forces one to see the world differently. When an individual sees the world differently, he or she constructs a new narrative, a new biography of themselves and of the person who has died." The only way out of John's desperate questioning and resultant mental suffering, was to change the narratives he told himself about Luke's death.

*To change the focus from death and loss to an ongoing relationship means to change the pervading narratives.* I invited John to tell me about Luke the person, as a person whom I did not have the opportunity to meet while he was alive.

"My questions are designed to invite ongoing remembering practices. They are not designed to evoke sadness or loss. They are not intended to bring forth missing of future events between the dying person and their loved ones. It is my hope that this way of working with death and dying brings comforting reminders that our lives are not inconsequential. To know that they will not be forgotten is a source of peace for the dying as well as for the living. The significance of a person's life continues even if the person is not around to remind people." (Hedtke, 2010, p. 10)

*“Luke was a happy person until two weeks before.”*

*“People who met Luke often said how thoughtful he was; he made a difference in their lives.”*

Luke acted as mentor at Cadets and he was well liked by his peers.

*“He could joke around but got others to do the right thing”*

I remark that it is interesting that John had taken over this role that Luke played now. John smiled wryly, not saying a word. But in the months to come I saw him do more and more to prevent suicide among young people, and act as an informal mentor to many of Luke’s friends. I don’t believe this was only to rectify somehow what he could not prevent with Luke, but that John, and Luke, are both caring, giving people by nature.

*“Luke liked Combis, those old faded blue ones. I see them everywhere now.”*

*“Two months before he died, Luke took up smoking. Sometimes I get a sense of smoke, like through the vent of the car or so, and I think it’s him.”*

John attributed seeing the Combis and the smell of cigarette smoke as messages from Luke that he is fine and still with them. This brought him some comfort.

*“Luke was very interested in the Air force; it was a bitter disappointment for him when he couldn’t go because of his health.”* (He had an irregular heart rhythm.)

John went on to tell me about youth programs for at-risk teens Luke was involved in. He didn’t say so, but I could see the pride on his face as he told me about what Luke accomplished in his young life.

### **5.4.3 The Loss of the Wholeness of Family**

It’s hard to imagine for an outsider how much a household can change when the youngest member suddenly isn’t there anymore. When one buys groceries and you have

to remind yourself not to buy his favourite food, or you start cooking for two instead of three. When evenings and weekends suddenly seem too long and too quiet. When a father comes across something he wants to tell his son, and remembers that he's not there to tell him. At a time like that, flippant remarks or platitudes make no sense to a bereaved person. *Narrative empathy*, honest listening and allowing the person to completely unpack and deconstruct all the facets of his grief allow the natural flow of feelings and so, hopefully, bring relief.

Luke was his parent's only child, conceived after many attempts at in vitro fertilization, a son very much wanted and loved by his parents. He completed their family, in a sense made them a family, not just a couple.

*"Now it's just me and Emma at night watching TV and having dinner."*

*"It feels strange not to phone him during the day, to hear how he is. It even feels strange not to worry about him all the time."*

*"We've lost our whole world, our only child..."*

A few weeks before Luke's suicide, the family was discussing the suicide of one of Luke's school mates. Luke reassured them that he would never do something like that to his parents. Yet, in his suicide note, Luke wrote:

*'I see the hurt and pain I have caused my family, and this pushes me further from myself' and 'I can't hurt my family or friends anymore.'*

Somehow, in Luke's mind, he believed he was relieving his parents and friends of himself. John admits they were worried and sometimes disappointed in Luke, for instance for taking up smoking when especially his mother is so health conscious. Yet:

*"We never thought of Luke as a burden! You know, all parents worry, and we knew eventually he would find his way. We loved him!"*

Emma had the words of the poem 'The Cord' tattooed on her arm after Luke died as a way of giving expression to the fact that they will forever be bonded. *'We are connected, my child and I, by an invisible cord'*.

#### **5.4.4 The Loss of the Father**

Being a father was a role John looked forward to, and though it was by no means easy, he mostly enjoyed it. As Luke grew up, John and Emma were often worried about him academically and sometimes frustrated with his choices. But Luke was very much loved. John had been used to communicate with Luke, often calling him at lunchtime to hear how his day was going. Sometimes the family would eat dinner or watch TV together and on Friday evenings John would take Luke to Scouts. These little rituals that punctuated their week became the fabric of their lives together. When John lost his son to suicide, a vacuum was created. John's identity as Luke's dad was snatched away, and suddenly John wasn't a parent anymore.

But almost immediately after Luke's passing, John took Luke's friends under his wing and helped them out practically and with advice whenever he could. Many of his friends came over regularly, reminiscing and telling funny or sad stories about Luke.

John became actively involved with Luke's old Scouts group which took quite a bit of his time and energy, which he gave graciously. Almost every time I saw John, he had a story to tell about a youngster who seemed a bit adrift, that he guided and helped.

John hadn't stopped being a father after all. In fact, he possibly became even more fatherly, as he helped and guided and mentored and loved scores of young people, and who knows, maybe prevented a few tragedies along the way.

#### 5.4.5 Luke as a Member of a Community

Luke had a tattoo on his left arm that he designed himself, with symbols he liked from the Vikings. John later had a similar image tattooed on his arm which he showed me, a simplified replica of one that Luke had, in memory of his son. Luke also had tattoos of the names of his great grandfather and his uncle.

We are all connected, not just parents and children, or family, but the community of life, and when Luke died, a whole community, friends and extended family, mourned. On the day that Luke passed away, a nephew was born and John looked thoughtful, not quite saying the words that he wishes Luke came back in the new baby. John and his wife were asked to be the baby's godparents, he was quite touched by that and felt honoured to be asked.

Uncles, aunts, cousins, nephews, nieces and his maternal grandmother all suffered the loss of their nephew and grandson. It was important to have Luke remain a member of his community and family, and this seemed to happen quite naturally as his friends often talked about him, or his younger cousins still looked up to him.

In a letter to Luke, John wrote about Luke's cousins:

*"I can't wait to have all the boys together for a sleepover. You would have loved it if you were here to help me with the boys. They look up to you, you know? They always talk about you, they love you. Action Man car and Storm Trooper figurine."*

John goes on to mention every one of Luke's closest friends, 'telling' Luke how they are faring and how much they are missing them.



*“Luke has many great friends. They have been to Luke’s room amongst his stuff. When he left we gave them the special things like he asked us to in his letter.”*

John mused how the lives of Luke’s friends and family changed because of his death.

In another conversation, John mentioned how difficult Luke’s grandmother found the loss, sometimes he felt she made it sound as if her pain was worse than theirs. John also remembers how they went to a family birthday and people kept asking them if they are okay; they didn’t really know how to answer them. One of their family members implied that they should be okay by now and that they have cried enough already. Goss and Klass (2005) describe how grief becomes problematic when it is incongruent with the expectations within the narratives of grief of the bereaved person’s societal or family group. They explain that all societies have rules for how the emotions of grief should be displayed and handled that limit the development of alternative narratives by an individual through pressure to conform to the cultural norms. The authors note that one of the functions of social narratives is to police grief and that “those who do not conform to the social expectations are labeled aberrant” (p. 189). They, and other writers like Pavlovitz (2016) call them the ‘grief police’, those who are so uncomfortable with tears that they try to minimize or put unnatural boundaries on the bereaved person’s pain.

## **5.5 Saying ‘Hello’ again to a New Son by a New Father**

Louise Hedtke who writes beautifully about Narrative Therapy and grief, emphasises throughout her writing that eventually, the aim of grief therapy is to focus on what remains, not what is lost. “The resolution of grief often includes cultivating bonds of emotion and meaning with the dead. In other words, people who are important to us become part of our inner conversation and remain there after they die.” (Hedtke, 2010, p. 2)

To strengthen an ongoing relationship I thought it might be helpful for John to continue 'talking' to Luke and I encouraged John to continue writing letters to him. Though this was difficult for John at first, he found relief in the process and wrote a number of letters during the time of our therapeutic conversations. This strengthened the sense that an ongoing relationship with Luke was possible, albeit not the same one where a father might worry about his son coming home late or care for his physical wellbeing, but a relationship between two people who continued to love each other.

John expressed a sometimes complicated relationship with Luke:

*"I do love you and I always will. We did not always see eye to eye and had our issues, but I thought we were OK and that you would come to me if you were going through something. Well, how wrong was I, never mind."*

Sometimes John wrote about Luke's positive attributes in a kind of roundabout way:

*"She is not like you mate - you would do anything for your family."*

At times the missing became too much, and the loss of the physical presence of their son overwhelming:

*"We are trying to be strong Luke, but it's hard."*

*"You are our world and when you left it we are alone now. What do we do, who do we leave our things to, our house, our money? We were only doing this for your future."*

John's growth gained expression in another one of his letters to Luke:

*"Mom and I are getting on better now. We are talking more now than ever. Well, I am trying to talk more; apparently it is an issue with males not being able to talk how they feel. When I came home from my Psych and told Mom that I had*

*started my grieving she said I can help you now, just like you helped me just after you left us.”*

I hoped it would be a good time to ask John to talk to me as if I am Luke, to talk his heart out and say whatever he'd like to say to Luke. John started talking without stopping or seemingly catching his breath. It was a cathartic experience and it was like the dam wall broke. The words echoed what John had expressed in his letters to Luke and to me, but with much more intensity, using personal pronouns changed the words from general feelings to specific hurts, and the emotions that came with them echoed the force of the experienced jumbled emotions of pain, confusion, upset, annoyance and love:

*“You did not come to me or the multitude of people you could have gone to. You admitted you needed help but did not follow through. You obviously felt really down and you did not reach out to your best bro’s. You obviously thought you could not come to us, but why? I am really struggling with this. Did we not always help you out?”*

*“I am disappointed and frustrated and yes, I am angry because you were too stubborn to ask for help. I know you got this from me. We are male and we always say we are okay. You are such a passionate person and deep thinker and you have clear emotions about people. But sometimes you are closed like a book. When it came to important things you didn’t want to know and it annoys me.”*

The session ended on a fairly positive note. John seemed relieved to get off his chest what he wanted to say to Luke all along, but couldn't. It was also a relief to admit to uncomfortable feelings such as annoyance without being judged.

As time went by John started talking about Luke less as a (sometimes foolish) young man and his son, and more as a person. After struggling for many months with why's and how could he's, John mostly just accepted, even accepted perhaps that he might never quite

fully understand, and that that was okay. In the acceptance, slowly, a new relationship with Luke started taking shape. John was released from the anguish, the struggle, the anger followed by guilt followed by anger. Perhaps he was just spent from the struggle. For months he couldn't look at the pictures of Luke he had on his desk. But towards the end of our therapeutic conversations, John found himself chatting to Luke:

*“Well, I started telling Luke little things, like who came to visit or that his Mom and I talked about him on the weekend. Or what I was planning to build in the shed. And I noticed it became easy again to talk to him. It wasn't as difficult as it was. Sometimes I even said to Luke: ‘if you're up there seeing this, won't you help your mother a little with this or that’. And I'd have a little chuckle and get on with the day.”*

“The significance of a person's life continues even if the person is not around to remind people”, Hedtke notes (2010, p. 11). A soft turning point in John's grieving process was expressed in our sixth therapeutic conversation. By then John reported that:

*“the depression is better, sometimes I still have bouts of it, like last Sunday afternoon when I asked myself what am I doing? But mostly it's better.”*

## **5.6 Re-Authoring the Grief Experience within an Emerging New Identity**

Going back to enjoying pleasurable activities is a milestone in the grief journey. Most people don't feel up to it for a long while, while many also report feeling guilty because they are smiling or enjoying life after a tragedy. So, when John and Emma took up dancing again as they used to do before Luke's passing, I knew he was starting to heal, both of them were.

*“We used to sometimes have these awkward silences between us when we didn't know what to do. But we seem to have gotten ourselves to a better place.”*

John and his wife are quite religious, having been brought up in the church. This experience expanded their faith and brought a spiritual depth to it that wasn't there before. Throughout our conversations, John would use sentences such as *"it all happens for a reason"*.

John reported a deepening of his spirituality and said that he started to believe that

*"...souls return. Sometimes I wonder about Luke's cousin that was born just after he died..."*

*"There is a point to life, there's got to be, there must be reasons why, I just don't fully get it, understand it."*

A newfound sense of purpose directed John's actions when he became not just involved in suicide prevention programs, but an active driver of some new ventures. He organised fund raisers and spoke up whenever he could. He even appeared as a guest on the radio to talk about suicide.

During our many conversations I saw John emotionally grow through various emotional experiences: at first he was sad and upset, even angry at Luke for doing what he did. John said from the beginning that he had forgiven Luke for what he did, but was thrown when I asked if he had forgiven Luke for what he didn't do. His struggle with forgiveness is reflected in his words:

*"Yes, I have forgiven him but I am still very upset he did not cry out for help, we would have been able to help him and he would still be here. I am still deeply disappointed in him for what he did, and I will be forever. The world was his oyster; he could have done many things, all he had to do was set his mind to it and focus. I said that to him before he did it but like with a lot of things he didn't listen."*

And realising the futility of his ponderings and his inability to change the past:

*"Anyway, it's in the past. Can't worry about it and can't change it."*

Eventually John became tired of the ruminations, of wondering why Luke chose to end his life rather than coming to his parents for help:

*"I am tired and I want to be able to move on, I don't know if that is the right word."*

John's changed priorities are reflected in these words of his, around the time of our tenth therapeutic conversation:

*"I have made some decisions, I am going to spend more time at home and start going with my gut instinct and doing what I feel and think is right. I do have a sad story and a heart-breaking story, but I am strong and brave."*

## **5.7 Identity Growth as John Gives Back**

For Bakhtin (1981), one of the things that make us human is that our identities change and adapt. Our life narratives are always, in his words, 'unfinalizable', as more life experience, meanings and interpretations are brought to the identities we hold of ourselves. Our identities, Bakhtin explains, are constructed in dialogue with others and ourselves. His theory of narrative discourse holds that as humans we are constantly shaping and constructing new identities. It is exactly that aspect of our humanity that is addressed in therapy, I believe, as we ask questions, or reflect un-storied occurrences to our clients, and point out their 'sparkling moments' as Gerald Monk et al. in *Narrative Therapy in Practice: The Archaeology of Hope* (1997) call them. These moments change the otherwise problem-saturated story into a narrative that points to the possibility to live a meaningful life despite the loss, and sometimes ironically because of the loss.

I asked John how losing Luke had changed him in one of our last conversations.

*"I'm a better person, I've done things I would never have done, spoke to important people, gone to places I wouldn't have gone to otherwise. I've got more to give now that Luke's died. Not more energy, but I'm more of an advocate for helping youth, I have*

*more time to help and be there for them. I'm also more aware of people's feelings and I'm paying it forward. I'm more honest with my own emotions, also to others. When it comes to Emma, now it's different. I find I comfort her more now. Sometimes I just make her tea. I'll also help more at home like start dinner or make the salad. It's not that I'm more compassionate, but I'm making more time to be caring."*

John gave of his time, his energy, his weekends and his resources. He gave advice and counsel to young people and colleagues, and he gave of his experience to others who might be going through something similar. He gave more love to Emma, and a helping hand to Luke's friends. John gave his energy to charities that help prevent suicide in young people by getting involved with fundraisers and helping to raise awareness. Perhaps one could say it ameliorated the feelings of helplessness he felt with his own son's passing, but to me, it reflected John's growth and the best of his nature. And as he said, it was up to him to do with this experience what he'd wish.

At John's work he was actively involved with *Mates in Construction*, a charity set up to prevent suicide and improve the mental health and wellbeing of workers in the building and construction industry. John got involved with on-site training programs and tirelessly encouraged colleagues not to ignore a person who looked upset or depressed, but to approach and offer support, something John did frequently. His natural caring nature was strengthened and John showed vastly increased empathy and compassion for his fellow man. There wasn't a conversation between John and I when he didn't tell me how he uplifted a young person and was involved in a charity.

Re-authoring the grief experience in alignment with his new identity was important for John to do. That implied accepting the almost-unacceptable. It meant he had to allow the uncomfortable truth to live within him, within their home, and still find as much joy as he can. It tasked him with using his terrible loss as impetus for doing good. It also meant he had to feel joy without guilt, and had to continue his relationship with Luke

even when he stubbornly could not approve of what he did. It meant that he had to continue loving his son as deeply as always, even though his son had so bitterly disappointed and hurt him. We laughed together that that is probably the job of all parents – to love our children even when they continuously hurt and disappoint us.

I was reminded of the quote about forgiveness: ‘I wondered if that was how forgiveness budded; not with the fanfare of epiphany, but with pain gathering its things, packing up, and slipping away unannounced in the middle of the night’ (Hosseini, p. 313) when John reflected subtle but steady growth towards the end of our therapeutic conversations together:

*“I’ve asked myself if he had not died how things would be. So many things have happened, our godson being born on the day he died, and so on. Would I have been so close to his mates if this hadn’t happened? No. Would I be so passionate as I am about preventing suicide? No. My only free will is what I do with this, and maybe one day I will know. Accepting, not just him not being here, but also accepting I don’t know why. Sometimes I can, sometimes I can’t. I look at his pictures now; I make sure I don’t forget him. In conversations he often comes up, like with his friends, and I don’t avoid talking about him.”*

John had changed. He had become wiser, sadder, softer. He had become very very generous with his time and counsel, especially to young people. John had become a pillar of his community – at work, at his church and at Scouts. John had become a mentor to many a young person, especially to Luke’s friends, but also to any young person who came his way. He tried his best to care, to reach out, to uplift, and to give practical advice, money or an ear to listen to. He organised fund raisers and this normally soft spoken man spoke out at his work and in church and in seminars to raise awareness about suicide.



It's not that the sadness left completely. Or that John didn't sometimes feel anger at Luke for leaving and not seeking help. Very often when he spoke to young people and encouraged them to get help when they felt depressed some of the old pain resurfaced, but to a much lesser degree. And it's not that John didn't cry anymore. In fact, I think John's tears came more easily, but he seemed to regain his composure just as easily. He also did something he never did before, sometimes he would cry a little with Emma, or reminisce and become sad, and then got on with living. In general, I believe John was more natural with his feelings, and that was a major contributor to his healing.

As Shapiro & Ross remind us "The overarching goal of narrative therapy is to help the patient replace the problem-saturated story by constructing a preferred story." (2002, p. 97). A story or narrative that has been fleshed out with the experiences of all role players, with stories of life not just death, but also death and what it means, a story that is rich and multi-faceted and includes beauty and rounded characters allows a bereaved person like John to open the door to healing and growth. This story allowed a continued but changed relationship with a son that did the almost-unforgivable. The on-going relationship became possible exactly because John could construct a life-affirming, inspirational story from one of deep loss.

## Chapter 6

### Mia's Story: Dis-covering an Emerging Identity following a Life Changing Tragedy

*"What the caterpillar calls the end of the world, the master calls a butterfly."*

~ Richard Bach (1977, p. 177)

*"Women were created from the rib of man to be beside him, not from his head to top him, nor from his feet to be trampled by him, but from under his arm to be protected by him, near to his heart to be loved by him."*

~ Matthew Henry (2010, p. 129)

#### 6.1 Personal Data

Participant:	Mia
Age:	Mid forties
Field of Occupation:	Finance
Education Level:	Bachelor degree
Therapeutic Setting:	Psychology private practice
Language:	English
Therapeutic Conversations:	21

\* In the final report names and some identifying particulars were changed in order to protect the identity of the participant.

#### 6.2 Introduction

One of the most harrowing stories a therapist can ever encounter was narrated by Mia, a woman who looked at once fragile and strong. Attractive, tall and slim with beautiful

blue eyes that have seen far too much of the sad side of life, she was a striking figure when she entered. Mia moved with grace, spoke softly and clearly with a beautiful accent, but there was a guardedness about her eyes and in some of her movements, a tension in the way she held her body – she seemed to try and hide an expectation that something very bad could happen any moment.

When Mia and I had our first therapeutic conversation, she spoke about work and needing to decide about the direction of her career. She worked in the finance field and had steadily worked her way up with the help of a very supportive manager. Yet Mia had been feeling anxious and depressed for a while now, and something in her life needed to change. As her story unfolded, a deep loneliness was also revealed – she lived alone and missed the companionship of a close partner and family.

It was only in our second conversation that the reason for Mia's loneliness was explained more fully. Perhaps she had developed a degree of caution through her life experiences, and first needed to see whether she could trust me as her therapist. I was touched that she entrusted me with her story.

### **6.3 Mapping Influences**

Mia is Croatian but has lived in South Africa for two decades. She has remained Roman Catholic throughout her life the way she has been brought up and her faith gives her comfort and consistency. Mia is 44 years old, and widowed.

In Mia's life there were definite chapters, we discovered. As a child she remembers her parents as strict, although she had a fair bit of independence. Life was hard and her family had little money for luxuries. She remembers needing to grow up quickly:

*"I was six when my mother packed away all my toys in the attic and said to me that I am a big girl now. I didn't feel ready to be a big girl. I was upset about that for months, but my mother didn't want to change her mind. She wanted me to learn to be independent and as a schoolgirl, she believed I shouldn't play with toys anymore. I was told not to cry about it, so I cried only after I went to bed when I was alone."*

This vivid memory of one of Mia's first losses and how to deal with her emotions left an indelible impression, and probably influenced how she dealt with losses later in her life.

Mia remembers the weekly wages being put in a bottle and that money was carefully allocated to different expenses. Her mother gave her money for lunch every weekday and she was told to buy a sandwich. Mia remembers with a smile:

*"Well, I didn't buy bread, I bought cake every day, and my mother didn't know."*

At the time she was tasked with taking care of her brother and some household tasks, and this was probably her only little rebellion she could get away with. Mia noted though that she learned self-discipline early on which she believed stood her in good stead in her life.

The *Croatian War of Independence* (also called the *Conflict in Yugoslavia*) was fought from 1991 to 1995 between Croat forces loyal to the government of Croatia - which had declared independence from Yugoslavia and the Serb-controlled Yugoslav People's Army (JNA), and local Serb forces, and ended with a total Croatian victory and independence. However, it had left much of Croatia destroyed and the economy crippled. It was in the wake of this war that Mia, a Croat, met and married a Serbian man.

From 1918 to 1991, Croatia and Serbia were part of Yugoslavia and after the war Croatia gained independence. Today many thousands of Serbs still live in Croatia and Croatians in Serbia. Although there are many reports that relations between the two nations are

better than in a long time, some tension and distrust on a grass roots level remain. Croatia's relationship with Serbs and Serbia has been long and tortuous, sites a BBC article published in 2013. The two languages are very similar. When it comes to religion, Croats are traditionally mostly Catholics though and Serbs are Orthodox. Croats write with the Latin alphabet, and Serbs use both the Latin and Cyrillic alphabets. This background is part of Mia's story, who lived through the war, the devastation thereafter, the economic challenges, and importantly, the prejudices that remained.

After the birth of their son, Mia, her husband and son moved to South Africa with the hope of building a better life.

#### **6.4 The Loss**

Six years ago, Mia came home to find her husband had stabbed her son to death, and had shot himself. Mia tells me the news quite calmly, her face barely showing emotion as she stared at a spot on the floor. If ever there was a time for *narrative empathy*, this was it. It is important for a therapist to respond to news like this in a way that is both authentic yet helpful. At this moment I wanted Mia to feel less alone than she had been feeling for so long, and went to sit next to her. It was imperative that what she was telling me be acknowledged with the respect and recognition of the pain it deserves. Furthermore, I believe it is crucial for a therapist to find the balance between being authentically warm but avoiding pity which disempowers a person who has already suffered such an unimaginable loss. The narrative therapist is a compassionate and committed ally, a collaborator and co-solution finder with the client and I wanted Mia to know she was not alone: we were looking at this together, trying to find solutions together and helping her heal together. In line with the suggestions made by Michael White, I asked if she was up to talking about this, and how much.

Mia was open and told her story calmly, keeping her composure throughout. She mentioned that she had seen a grief counsellor after the event and had told her story many times. It was striking to hear her relate such a heart-breaking story with such calm

composure, almost detachment, as if she were telling somebody else's (hi)story. It only became clear in later conversations how much depth and pent up emotions were being held very tightly reigned in under the still, sad eyes.

Mia related the murder-suicide calmly: after many years in an abusive relationship, she had finally made up her mind to leave. What convinced her was that her husband called her son the Serbian word for bastard because he was of mixed blood, and physically abused her again, as he did many times before. She decided to divorce him, she had come to the end of her tether.

Soon before her decision to leave, Mia one evening picked up her son Marko (who was sixteen at the time) from his work at optometrists. Marko saw that she'd been hurt, and finally said *"Mom you have to go."* Before that day, Mia recounts, Marko never wanted to take sides between herself and her husband.

*"I came home and I told my late husband that I wanted a divorce. He just stood there and he didn't do anything."*

At first he seemed to take the news well, almost too well, and he said that he'd move out, which he did for two nights. Mia felt a sense of relief wash over her:

*"At last I thought I was free. I didn't expect it to be so easy for him to agree to that, but he did. For two days it was just me and Marko and we had peace."*

Perhaps it was too easy after all the many years of abuse and control. Mia uses beautifully descriptive language and noted:

*"I remember I looked up at the blue sky, it felt like I could stand on my toes and touch it and take full breaths of air."*

Little did she know that he had other plans, and her relief was short-lived.

Two days after her husband moved out, Mia came home to a murder scene –

*“It was like being in a horror movie. Everything was different, everything looked different”*

Outside her house were police officers and an ambulance. She was shocked and didn't know what had happened. In that instant her home had changed into a crime scene and her life would never be the same again. Mia later learned that her husband had called her boss, and told him what he was going to do, and told him to call the police. Then he stabbed their son several times in the back before shooting himself. It was clearly an act of anger and vengeance and Mia reeled from the shock. She could not believe what she heard, what she saw, what she was told. The sense of disbelief stayed with her for a long time, and even until today there are times when it all seems unreal, like a terrible nightmare she just can't wake up from.

It became clear that another contributing factor to Mia's calmness was not just the time that had elapsed since the murder, or the counselling she had received, but also the almost dreamlike disbelief she sometimes slipped into, a cocoon of pain that felt unreal, like a very bad dream. It was therapeutically important therefore that Mia accepted the horrible facts, and with time, learn to embrace the present.

We ended session two with coming back to the present day and her present concerns like work which grounded her in 'normal' life.

## **6.5 Re-Authoring the Grief-Experience and Externalising the Problem**

Mia came to our next therapeutic conversation a little more relaxed in posture, and seemingly not quite as guarded. She also seemed to show a little more emotion – a break in her voice, eyes tearing up, but not much more. We discussed her role on the day of the incident.

I asked Mia to tell the story of the fateful day again, but this time with emphasis on what she did, what she felt, what she said and how she responded. She related the trauma

with some distance, like describing a movie or theatre scene. Interestingly, these questions sparked memories long forgotten - phone calls she made to her boss, informing police officers of details of things like car keys and her husband's whereabouts, and so on. *Externalising the problem* as something separate from her, helped Mia gain perspective, and interestingly also showed her that she did make contributions to the investigation, did make decisions and was to some extent more empowered than she remembered until now.

It was a long journey to healing still, and this time Mia did cry a little as we discussed how the trauma felt to her as a mother and a wife.

*"I couldn't go back to the house again... Before that it was a house I loved, but it became a strange place, a place of murder."*

I ask what she missed about her old home:

*"I used to love the kitchen... Marko and I used to sit there and talk by the kitchen table. Sometimes we would just sit there and talk for a long time, until it was late."*

Encouraging Mia to flesh out the details, not just the short 'police record version' but how she as a member of this family remembered and experienced things brought details to light that were almost forgotten. She remembered how police comforted her, that they were kind and calm. She remembered the details of her home and the way the late afternoon light came through the windows. Time slowed down as she was at the same time trying to frantically understand and yet finding herself in unfamiliar emotional terrain. Particularly pertinent to me was for Mia to develop an *identity that would have more facets than the widowed victim*. In relating the story to me from an *external-to-the-problem perspective*, interestingly the details increased, and she could remember more of a sense of herself as observer and participator.



## 6.6 Grappling with a Most Unnatural Death

In grief therapy it has often struck me how clients find themselves *traumatised by the death and dying of their loved one*, compounding and complicating *the grieving of the loss of the person in their lives*. This happens seemingly whether the person died a natural death or a most unnatural death as in this case. In my opinion the shock and trauma of the passing first needs to be discussed and overcome before the process of *remembering* could effectively take place. As much as seemed natural and helpful, Mia was allowed to narrate in her own words the horror of lifeless bodies and stab wounds and blood everywhere, words she could not or would not utter to anyone. The horror of the fateful day could slowly be talked through, before the work of grief counselling and growth could start in earnest.

*“It was really horrible. There were Police and paramedics everywhere that first night. I couldn’t go into the house or into the kitchen. It was a crime scene and I just stood there outside with some kind Police people. Later, a friend went to the morgue to identify the bodies, but I did go to see Marko... He looked different because he was so still and pale.*

*When I was finally allowed to go into my own house again I just couldn’t do it. I stayed with friends from that very first night. I don’t know what I would have done without the kind people who helped and supported me. It still feels like a blur, those first weeks.”*

This process of unpacking the horror of the murder-suicide did not take very long as some years had elapsed since the murder, but it did seem to lessen the horror-content of her nightmares. Mia was quite calm when she told me the details of how her late husband went into the kitchen and plunged a knife repeatedly into the back of his own son, before taking his own life. She becomes angry, she admitted, when thinking about it, but Mia didn’t seem overwhelmed by it. Later on, as she spoke about missing her son,

the sadness was much more noticeable. I wondered if she was so stoic because of her experience as a young girl who had to let go of her toys without complaint.

## **6.7 Thickening the Narratives**

What was key in our further sessions was *thickening the narratives* to obtain a full and rich description of their lives together, her life before they met, and her life after the horror event.

### **6.7.1 The Complicated Grief that Follows the Death of an Abuser**

The retelling of her history as it pertains to her marriage happened throughout our many conversations, and not always chronologically. For the sake of flow I have set it out more or less in order, as Mia remembered it.

By session four Mia had grown more used to me as therapist and seemed to find it easier to discuss the harrowing past without the same emotional detachment shown before, but also without being flooded in emotion by the horror of it. She reported sleeping slightly better most nights, though she was still tormented by dreams of her husband. I asked her to describe a dream she had:

*“I was flying in an aeroplane, a small aeroplane. Suddenly, in my dream my late (husband) was on top of the plane, he was lying on top of it outside. Then he looked down through the front window at me with an evil grin, and he started to control the plane. I felt like I had always felt, so scared and out of control. Then I woke up frightened and I put the light on and I couldn’t sleep again the whole night.”*

The next day Mia went to work feeling like she was sleepwalking, again emphasising the nightmare-she-can’t-wake-up-from-feeling that has haunted her for so many years.

I asked Mia what she thought her dream meant.

*"I try not to think of my dreams as meaning anything, they are too frightening..."*

If she had to guess?, I gently nudged. She realised immediately the implications:

*"My late steered my life, he took control even when I thought I was getting more control. He always took control. In the end he changed my whole life in an evil way."*

Using the analogy, I asked Mia what her life would look like if she were to steer her life, if she were to be the pilot in the plane and her husband was not there at all to interfere. She thought for a long time before she answered:

*"I would be happy, I would be free.... I want to be happy."*

Mia has been reliving the murder scene in her mind thousands of times, staying stuck in a past without power. This tentative reaching to a future freedom where happiness is possible is therapeutically important and a theme we came back to many times in our later sessions.

### **6.7.2 From Fear to Freedom**

A dominant emotion in Mia's life throughout her married life, and thereafter, is fear. *Mia's grief process was complicated by two traumas: that of the murder and that of years of abuse before that time.* The death of a spouse who has brought her such anguish and misery is necessarily fraught with complexities. David Denborough describes this in his book *Retelling the stories of our lives* (2014: 239): "It is also significant to acknowledge that people's grief is sometimes complicated by experiences of violence or other forms of abuse. If the person who has died tyrannized other people, or if there was a lot of conflict or misunderstanding, then relating to the person's death can be complex."

Little by little Mia started to tell a story she had kept mostly to herself for decades. Mia described the relationship she had with her husband. They had met when she was nineteen and rather naïve about men. He seemed dashing and handsome, and wooed her, flattered her and convinced her that he would take good care of her.

Mia cannot remember being madly in love with him,

*“But I was definitely under his spell.”*

Things got complicated when they were to marry: he wanted her to convert to the Orthodox Church he belonged to and considered superior, and marry him in church. But his church didn't allow it, and Mia was silently grateful, at the time she thought that meant she didn't need to marry him. Unfortunately he persisted and in the end a civil ceremony was held with only a few members of their respective families attending. Distrust and prejudice between Serbs and Croatsians were still very prevalent.

Soon after the wedding the abuse started. Mia was reluctant to tell the full story, and bits and pieces were told in our many therapeutic conversations to follow. Mia's husband was excessively controlling, hit her often, degraded her verbally on a daily basis, told her she was worthless, a “dirty dog of a Croatian”, and shockingly, she told me later how he raped her as a means to further assert his power.

Yet in her own way Mia managed to have some power – she was the one who said they should immigrate to South Africa, and she was the one who chose her son's name.

But in other respects, her experience was of a woman without power. In her narrative description, she remembered:

*“I was working very hard in a supermarket while I was studying, and it was very hard also because my English wasn't so good at the time. After work I had to*

*come home immediately. If I was even five minutes late I was in trouble. I was not allowed to do anything else – just work, study, come home. Then I had to cook and clean and so on, he believed it was the woman’s work to do everything.”*

It was only in much later sessions that Mia admitted that her husband also raped her, physically shoved her around, and was verbally abusive. But to the outside world she endeavoured to put on a brave face. *The quest for inner strength became a major theme in our talks.*

When Mia and her family moved to South Africa, her son was about two or three years old. She didn’t know any English and worked hard in humble jobs until her English started improving and her confidence grew a little. She remembers riding to work on a bicycle and how she struggled to talk to her new countrymen about even simple things. She was isolated from society and for years without a local support network. And with the stress of immigration, the abuse at home got worse. Mia had no one to turn to, no one to confide in. She kept her emotions in check, and became an intensely private person, whilst at the same time yearning to connect with people and make friends. Her local church provided a safe haven from the world and her marriage and became her anchor through her many trials and tribulations.

When Mia related the story of her married life, she did it in a flat tone of voice and an almost expressionless face. Bits and pieces came out in different sessions throughout our therapeutic journey together. One day this is what she said:

*“My late would check up on me all the time, he was very jealous. He would call me often at work and while I was driving home in my car. Sometimes he told me to turn around and drive back to the same place on the highway and call him again, so he could hear if the sounds were the same.”*

*“A few times he drove very fast with me on the highway, saying he was going to crash the car and kill us both. I was crying and begged him to please slow down,*

*but he wouldn't. He just laughed and enjoyed making me scared. He would only slow down once he was sure I would obey him again."*

Mia lived in constant fear when she was with her husband, but slowly started growing stronger in the outer world as she worked her way steadily up in her career. She remembers proudly getting 97% for a finance and accounting exam she did. Professionally she was starting to free herself from his hold, but domestically she was still an emotional prisoner.

### **6.7.3 The Creative use of Language in Narrative Therapy**

In Narrative Therapy the symbolisms and *neologisms* that clients bring are often used therapeutically to enrich the story line and to help with re-authoring. In Mia's case her beautiful and interesting way of using English opened many such opportunities:

*"I lived a life separate from him. Sometimes I would go to bed at eight, just to not be with him in the evenings. I would work, long hours, come home, cook, clean, go to bed. I was in his shadow, under his foot."*

I wondered if she always felt she was under the feet of people, perhaps in other contexts?

*"At work I was different, I was always friendly, but I also sometimes had to put my foot down."*

This is one of the opportunities that Narrative Therapists look for – a moment where the client move away from a dominant story that has kept them down, and open up to themes that would foster more health, and in this case, examples of feeling empowered. And so we used the analogy of the foot therapeutically (and with a bit of humour) throughout our following sessions such as 'growing into your shoes', 'filling your shoes', 'putting your foot down', 'toe the line', 'one step at a time' and 'a step in the right direction'.

Another symbol that very often came up in our therapeutic conversations was about light and darkness. Mia remembered her son in the sunlight or against the light of a window, and the light on his hair. Mia's son Marko was the "sunshine of my life". When thinking or even dreaming about her husband the images and thoughts were always heavy and dark.

Later on in therapy, Mia described how she would sit in her bed having her morning coffee seeing the sun coming through the windows, feeling peaceful. At last, her bed, her home, had once again become her sanctuary.

When I met Mia, she referred to her late husband mostly as "my late". I commented on it once about midway through our therapy.

*"It is because I really don't know what to call him. I can't call him my husband. And I didn't divorce him, so I can't really call him my ex. And I don't want to use his name. So I don't really know..."*

I asked her how she would describe her relationship to him in terms of her current feelings. Did she feel married to him? Did she love him? Does she feel like a widow?

*"No, I don't love him and I don't feel married to him. I think even in the marriage I didn't love him. (Silence for a few minutes as she contemplates this.) If I have to tell you how I feel, I would say that I am divorced from him, or I wish I was."*

I asked Mia how it would feel if she called him her "ex" and she thought it sounded more true to her feelings, and also spared her from having to explain to people how he died when she spoke of her late husband. From then on in therapy, we switched to talking about her husband as her "ex" which facilitated further emotional distance from the man who had such control over her actions and thoughts for far too long.

#### 6.7.4 Forgiveness and Growth

Within the field of grief and bereavement, there is a commonly accepted notion that forgiveness is an essential cornerstone of 'moving on' and 'letting go'. As 'moving on' is not a concept held by Narrative Therapy as it pertains to grief counselling, this concept needs to be re-examined. Clearly, if a person remains stuck in anger and trapped in a victim-like identity, healing cannot take place. Mia brought up the concept of forgiveness towards the end of our therapeutic encounters. She mentioned that she has "*given it to God, it's too big for me*" as she has found herself in the past struggling for the motives behind such a dark act. Why not just take his own life? Why destroy her son at the beginning of his beautiful life, and through that also hers? Surely there must be a lot of hate; surely he must have been very disturbed? Mia admitted that thoughts like these have kept her awake many a night as she tried to make sense of something so nonsensical. I mentioned that I did not believe forgiveness implied condoning. She answered quite wisely:

*"Yes, forgiveness means peace in my own heart".*

It was clear that as Mia started to *redefine her identity* as no longer her late husband's wife nor the woman who had lived through a tragedy, the "peace in her own heart" grew.

An important explanation about forgiveness in terms of Narrative Therapy is given by Lorraine Hedtke in her 2002 article *Re-thinking deathbed forgiveness rituals*. If Narrative Therapy holds that the act of re-remembering means that a deceased person can re-join the group of people who continues to love him or her, then by the same token it implies that re-remembering is a choice that is up to the bereaved: "I would venture that when there is a desire for forgiveness in a connection, that somewhere along the way the individuals involved had a change in membership status. Forgiveness does not just happen in a relational vacuum. The story in which it features is more important than any single magical act. I am using this term, membership, specifically here as a statement of



privilege that changes over time. Membership status is not a biological birth right. Rather, it is a living connection that grows and shapes and changes over time. When intimacy is nurtured, membered status can grow more important. Conversely, when harm is created, membered status can be downgraded or severed.” “These revisions involve the transformation and re-writing of stories of relationship. Through the re-authoring of stories we can choose to revise our relationships with those by whom we have been wronged. In this process, the emphasis is not on forgiveness being a transformative act, so much as on the construction of a transformative story of relationship, in which various acts of forgiveness, apology, and story revision might take place.” (Hedtke, 2002. p. 3)

In Mia’s case, transforming the relationship she had with the man that caused her so much harm was crucial for her healing, and beautifully expressed in her choosing to rather talk of him as her ex. In this way she could re-author the story, and her role in it, and her role after the tragedy, to one where she was more empowered, and able to escape the gripping power of a cruel man.

The following week Mia started our conversation by telling me that she has started “*a painting of peace*”, and has chosen the colour green to represent the growth towards peace. In a sense she was scripting a new emotional state through a concrete representation in a medium that was natural to her.

## **6.8 Saying ‘Hello’ again as Marko and Mia continue their Relationship Differently**

Michael White wrote an article in 1988 entitled *Saying hullo again* suggesting that the relationship with a deceased person can be re-established and strengthened in therapy, thereby assisting an individual to resolve protracted grief.

When a young person dies there is a sense of wrongness, that the person has not lived their full life and experienced growing up, going to university, becoming a father and raising children. For any parent the thought of their child dying is inconceivable. Most of us cannot imagine something worse. To lose your only child, and that at the hand of his father, and through multiple stab wounds, is something so huge I suspect most of us would remain stuck in a place of pain for the rest of our lives.

The shock and betrayal Mia felt after the murder-suicide and the trauma of the violence remained with her for a long time. But the terrible loss of losing her son remains with her to this day. As it often happens in grief, for weeks after his passing Mia expected Marko to walk in through the door, or call her phone. The thought of him not alive anymore was simply too big to comprehend. But gradually the truth of his absence started sinking in and she started to miss his laugh, their conversations around the kitchen table and having him home when she came back from work.

Mia's son Marko was the *"sunshine of her life"*. He was a sweet child with dark hair, intelligent and gregarious. Marko was quite outgoing and very well-liked by his friends. After her son was born, she decided not to have more children, *"because, you see, it wasn't a happy marriage"*, she said simply.

Before he died Marko had career ambitions and dreams which were starting to take shape. He was popular and used to meet up with his friends often. At school he did well and played basketball and his easy going, friendly nature ensured he was well-liked by all.

After his sudden passing the whole community mourned. Mia went to his school where a commemoration service was held and managed to give a speech with composure. She was very touched and proud that her son had made an impression on so many in his short life. His friends remain in touch with her until today.

Telling stories is a natural thing for humans. *In post-modern times, stories are sometimes told on social media sites.* A memorial site was created on Facebook for Marko and his friends regularly post on it. Stories of remembrance are shared on it, or sometimes after a basketball match a post would go up by a friend who remembered and missed him. This was a wonderful way to keep Marko's memory alive and *re-member* him also in his friendship group. Through their on-going stories the relationship with their friend continued, even when his voice was silenced.

Great was Mia's dismay when her husband's family started to make nasty comments on Marko's Facebook page. They implied that Mia was to blame for the murder-suicide. Their stories were bitter and full of hate, complicating Mia's grief even more. Many families create a sort of shrine or place where their loved one is remembered. For some it is as simple as a place with a photograph and a candle, which Mia did have in a fairly informal way. In some sense Marko's Facebook memorial page was such a shrine, though more public. The fact that her husband's family chose to defile it with long angry messages was like sullyng his shrine and sacred memory. This complicated and uneasy relationship with her husband's family remained a thorn in Mia's side, one she tried her best to live with, with as much grace as she could muster.

An important part of growing through grief is overcoming the heart wrenching sadness as far as possible whilst maintaining a relationship with the deceased, a relationship that necessarily implied that relating would be different, but no less loving. The task of the bereaved person is to find a place for the voice and the stories, and through the on-going stories enjoy an on-going relationship. Hedtke (2010, p. 6) notes "this approach encourages the bereaved to find a place for the ongoing introduction and incorporation of the dead into new relationships rather than consigning them to silence in the past. This practice gives the voice of the dead a chance to continue to reverberate in the stories that are told about them. Finally, it ensures that the story of grief does not remain in the singular story of loss but is opened up to a rich world of multiple stories."

Consequently, I asked Mia to tell me more of the memories that are dear to her as Marko's mother:

*"I remember making Marko sandwiches for school and washing his basketball clothes... I loved cooking for him and making him food, he was always hungry! (laughs) He used to enjoy what I made him...."*

Mia missed being a mother and a nurturer, she mentioned that by nature she revelled in her role as parent and found it most gratifying. Not having a son to take care of left her with too much time, and she did not enjoy cooking for one at all. It was a huge mind shift for Mia to make, to relate to her son in a different way.

The term re-membering was coined by Barbara Myerhoff in 1982 (as cited in Hedtke 2002) as a term to express thinking about a person's life as a club with members. Hedtke (2002) elaborates: "When we think about all those we are associated with in the course of our daily lives, we could consider them as members of our 'club of life'." and "We are able to revise our relationships with all the members, and these revisions can continue well beyond the physical reality of death" (p. 2). Re-membering implies more than recalling, it is ongoing nurturing of the stories of her life with her son included as member, not physically present, but present in her heart, her decisions and her experiences. I explained that through the continuing stories and memories and also by her mental conversations with him in the present, Mia could have an on-going relationship with Marko who continues to be her son.

In addition to re-membering, it is important for Mia to remember Marko as alive and well, and not as the stabbed body on the kitchen floor that haunted her memories for so long. As she reclaimed her memories and moved again to uncomplicated love and positive thoughts of her son, the emotions followed suit and became lighter, more joyful. Mia slowly moved to celebrating her son's life rather than living bravely with deep wells of private tears because of his death. Through the re-authoring of the story and the

resultant change of perspective Mia could view the experience as an opportunity for growth. She has become a mother of a person, not a dead boy.

As the stories of her life continued to weave, Mia could include Marko in them. I encouraged Mia to tell me as much as she could remember of her son, and she laughed as she remembered:

*“He had this special laugh; I can still hear him laugh. He laughed a lot. And his hair always hanged in his face, across his forehead. He had so many friends! Everybody loved him. He was enthusiastic about his sports and about his plans for after school.”*

Recalling the details of his life meant that slowly the acute feeling of loss is replaced by pride in her son for what he was as a person and how he touched the lives of others: a young man who continued to be loved and remembered by his school friends, as they grew into young men. Hedtke notes “the shifts produced by remembering conversations can produce an enhanced sense of agency in people’s relationships with their deceased loved ones and sometimes with others in their lives. Often relationships continue to be reconfigured after a death. For the bereaved person there is also a frequently reported sense of identity development that takes place.” (2010, p. 26)

What would it have been like if this tragedy never happened? I asked one day. Mia mentioned her son would have been 23 by now, he was in grade 11 when he died. He loved basketball and was accepted to the national basketball team through being invited to play for Wits. Marko loved music and for a while considered a career in music, but later decided to study to become a marketer and importer. She supposes he would have finished studying by now, and imagines she would have been divorced, and living with her son.

I encouraged Mia to write a letter to her son to strengthen the notion of an ongoing relationship. Kennedy (1997, p. 77) notes that with the writing of such letters, clients often experience significant shifts in their grief, as well as experiencing a sense of increased connectedness with the deceased, which enables them to bear the pain of the loss much better. Mia wrote the letter slowly over many weeks, and asked not to share it with me because she felt it was sacred and private. Mia admits to crying and laughing as she wrote it on her bed in the evenings, concluding that she made a point of telling her son that he continued to be very important in her life and that she was so grateful that he was born to her. In her own way, Mia was *saying 'hello' again*.

## **6.9 Re-Authoring her Experiences in Alignment with a New Emerging Identity**

In contrast to many other psychological theories that place emphasis on the process of individuation through inner world constructs, Narrative Therapy proposes that identity is rather co-created in relationship with other people as well as by one's history and culture: a person's identity is socially constructed. 'Thus, being seen by others in a certain way can contribute as much as seeing oneself in a certain way. We come to see ourselves by looking in the mirrors that other people hold up for us.' (Sween, 1998, p. 5)

In Mia's case, if the identity that was held up to her by an abuser that preferred to see her as lesser-than, as worthy of abuse, disdain and distrust, the journey to an identity as a woman who is strong, capable and worthy of trust and respect is a long one.

Growth is an on-going process for all of us. We grow best when we reflect about the events in our lives, and the lessons we learned. As such, therapeutic conversations are an opportunity to reflect, to examine, to learn from, and to eventually look forward to the future. As we hear ourselves narrating the story of our lives in the presence of an accepting and compassionate ally, we may shine a light on subconscious material, we

thicken the narratives and come to new conclusions, and if we are courageous enough, ask ourselves what we would do differently now that we have the benefit of hindsight.

Mia was willing to explore in great detail the many stories of her life. She didn't flinch at narrating the sad history of her marriage, nor did she back away from talking about the tragedy. Mia courageously stepped into a new identity throughout the weeks and months of our conversations, step by step allowing herself to step out of the jail of fear where she could have remained forever a victim, and into an identity of authentically herself. Mia must be one of the most courageous people I have ever met.

Mia's growth as a person after the tragedy started in a rather unpleasant way. Soon after the tragedy, she found out her husband had sent emails to his mother before the incident, telling her that he had slept with prostitutes, and may have AIDS. Mia suspected he did it on purpose as revenge, to get her infected with the virus after learning that she wanted to leave. So besides dealing with the loss, the immense amount of paperwork, insurance, the banks who were relentless, a burial in Croatia and so on, Mia also had to deal with possibly being HIV positive, and getting treatment for this. Mia remembers that her doctor was *"amazingly supportive"*. She also received practical and emotional support from a couple who had been their friends through the years, and she stayed with her friends for six months. She is very grateful to her boss who was understanding and has also supported her professional growth through the years. This support balanced her belief in humanity and was invaluable in a time where she was shell-shocked and felt bitterly alone and bereft.

Unfortunately, on top of everything else, Mia had to learn how to deal with difficult and deceitful people. Three weeks before the tragedy, her husband bought a 4x4 vehicle, and she was suddenly left with repayments she couldn't afford. Someone said they'll buy it from her, and pay the instalments, but stopped paying after the first month and tried to sell the car. With the support of her boss she managed to sort this out, but found it

incredible that people could be so cruel to someone who had recently been widowed and lost her son.

After the horrible and intense period that followed the tragedy, Mia had to pick up the pieces of a very changed life, and start building a new life where she no longer had the role of mother, no longer that of wife. It was only then that she could start grieving, but with the many things she had to take care of, grieving was a luxury she could barely manage the time and energy for. Though she thought of suicide, she did not want to give her husband the satisfaction and a steely determination grew in her, a determination and resilience that was there since her childhood.

*"I did not want him to win, to destroy me too. But it was really hard some days."*

Mia managed to work, to go to church, exercise, even to socialise. But despite outward appearances, Mia did not completely heal from the experience. She remained bound by the fear as could be seen by her continuing nightmares through the years following the tragedy. Mia would leave the light on all night, and she developed a bed time ritual of closing the cupboard doors *"where it felt like he could hide"*.

Mia's identity had remained that of the abused woman, despite not physically having her husband's presence in her life. Re-authoring her identity was the key to unlocking the jail she found herself in.

It was clear from our conversations that Mia had felt completely at the mercy of forces out of her control:

*"It was like being a small doll in a big storm"*.

In the murder of her son, as in her marriage, decisions were made for her that profoundly influenced her life, and nothing could have prepared her for the loss of her



darling son at the hands of the man she lived with, ate with and slept next to for eighteen years. This *profound sense of disempowerment* kept her captive not just in the marriage, but also in the years of grieving thereafter.

It was time to *externalise the problem*, to rewrite the story in such a way that she could see herself as an agent of power. “Helping people to find alternative stories and descriptions of themselves as capable, competent and even heroic in the face of problems is the task of the therapist” (Evans, 2003, p. 10). Mia was no longer practically bound by the dominance of an oppressive spouse, yet she remained part victim – part survivor. It was crucial for Mia to reach a place of wholeness, to find her identity as her healthy self, affected by her history, shaped by the events certainly, but her own whole person.

White (1997) believes that in therapy, clients can explore whose voices they want to be recognised when it comes to their identity, to inform how they see themselves. *It was time to change the voices she believed described her identity.*

In a social context Mia tried to avoid being pegged as the victim of a terrible crime. She avoided talking about the tragedy to people she met, as she did with me initially. Instinctively she knew she wanted to be seen for herself. We are social beings and to a large degree define ourselves in relation to the other members of our group around us. Whilst the decision to not divulge her tragic past helped in terms of not being reduced to ‘only the poor woman who suffered the loss of her son and husband’, unfortunately it also meant carrying the burden of this characterisation alone.

Carrying the burden of the tragedy drained Mia’s energy. Following the suggestion of *utilising symbols and the novel use of language as therapeutic tools* in Narrative Therapy theory, we elaborated and used images of a heavy dark burden carried on her shoulders,

weighing her down, and gradually shaking this burden off. I asked Mia to write a few words about what she would look like, walk like, smile like, and talk like if she were to be 'unburdened'. This opened a fruitful conversation and a long description of herself as free from the tragedy.

*"If this never happened I would be laughing more, going out more, painting more, trust more"*

I asked if she could imagine acting like that now? And little by little she did.

Mia started to go out with her friends more and enjoyed being single and free again. This was a welcome reprieve from the quietness of her home. The more she left her home for an evening of fun with friends, the more she relaxed and started embracing the life of a woman unfettered by the need of family obligations. Mia admitted that she would love to have deeper connections and communications, but for now this friendly interaction literally drew her out of her emotional jail.

As a child, Mia loved to paint. For decades she felt that life was too serious to paint, she simply was not in a creative frame of mind. Besides, the constant negative remarks by her husband discouraged her from picking up a paintbrush. In one of our first sessions I gently encouraged her to paint again, and suggested that for a while she may play with painting without self-judgement, purely for the sake of expressing. Mia joined an art class which she thoroughly enjoyed. Her painted landscapes and romantic pictures of buildings with vines and flowers suggested a sensitive, sentimental spirit. Mia worked for months on a painting for her parents and created a truly beautiful work of art.

After the tragedy, Mia discovered to her surprise that she had more resilience than she expected, but it was a struggle to grow,

*"I was just surviving".*

After years of just 'surviving, Mia gave herself permission to grow.

If the hypothesis is that in order for Mia to finally be free from the debilitating bonds of the past, she needed to escape the way her husband would describe her, then it was important to remove his influence over her. I asked Mia – what difference would it make to not have his voice in your head? This was a real struggle for her; subconsciously she always carried her husband’s voice and negative judgements within her. The question helped her to imagine her thoughts free from judgements and hearing her own voice more clearly. An identity could emerge of herself as no longer her husband’s wife or the victim of a family tragedy, but who would that be? It was a journey of discovery that spanned many weeks of therapy as she remembered that she loves European languages, that she is a loyal and generous friend, that at work she is quite professional and enjoys precise work. She reexamined her career, toyed with changes that would build on her love of languages, but eventually decided that her career as it was provided stability and the financial means for her to explore hobbies and travel. Different facets of her identity were celebrated, adapted, accepted and dismissed as we contemplated what they would mean for her work, where she’d call home and how she’d interact with people.

Was there any good that came from the tragedy? Anything you learned? I asked Mia. She was surprised by such an unusual question and answered after a bit of thought:

*“I became closer to God. I grew up in a Communist country and I didn’t even know how to pray the ‘Our Father’. After the tragedy I went on a two-week Christian course in Croatia and I started going to the Catholic Church here every week, I still do.”*

Mia’s outlook on life became more spiritual and she became increasingly aware of things that are eternal. During the time of our conversations she attended a weekend course on ‘what God means in your life’.

*“God became my companion, a comfort when I needed to talk to someone. He is always there, He seems to understand. I find comfort in going to church, lighting a candle, singing with others. It is a place I could feel at home.”*



She attends a Catholic Church nearby, even though there is a Croatian Catholic Church in the city. In the church community, despite not having close friends there, she has found a sense of family and belonging.

Has she grown? Mia believes she has grown in wisdom and understands people better.

*“I also didn’t know I could survive something like this. If somebody asked me long ago, would you go on if your son died? I would have answered ‘no’.”*

Mia chose life. At first she wanted to die too, especially in the first six months, but besides not wanting to give her ex the satisfaction, the thought of her parents kept her going, she believed they had suffered enough.

One of the most significant outward expressions of her change in identity happened towards the end of our therapeutic conversations – Mia decided to change her surname back to her maiden name. I celebrated with her, and suggested she write a final letter, a letter to herself, addressed to ‘the woman I’m becoming’.

## **6.10 Resolution**

At our last conversation Mia told me:

*“I am feeling free again. I can wake up early, have my coffee in bed and take my time to think. I can go out with my friends, go to the gym, and no one asks me when I’m going to be home or who I spoke to. I can go to paint class. I take better care of myself now. I have learned to eat more healthy food, and I like to be toned so I go to the gym often.”*

I have kept in contact with Mia and the last time we spoke she told me that she is dating a nice man, "*taking it slow*" as she slowly learns to trust and adapt again to the possibility of a man in her life.

## Chapter 7

### Cara's Story: Losing a father and friend

*Stop all the clocks, cut off the telephone,  
Prevent the dog from barking with a juicy bone,  
Silence the pianos and with muffled drum  
Bring out the coffin, let the mourners come.*

*Let aeroplanes circle moaning overhead  
Scribbling on the sky the message He Is Dead,  
Put crepe bows round the white necks of the public doves,  
Let the traffic policemen wear black cotton gloves.*

*He was my North, my South, my East and West,  
My working week and my Sunday rest,  
My noon, my midnight, my talk, my song;  
I thought that love would last for ever: I was wrong.*

*The stars are not wanted now: put out every one;  
Pack up the moon and dismantle the sun;  
Pour away the ocean and sweep up the wood.  
For nothing now can ever come to any good.*

Stop all the clocks, cut off the telephone

W. H. Auden

#### 7.1 Personal Data

Participant:	Cara
Age:	Early thirties
Field of Occupation:	Human resources
Education Level:	Bachelor degree
Therapeutic Setting:	Psychology private practice
Language:	English
Therapeutic Conversations:	15

\* In the final report names and some identifying particulars were changed in order to protect the identity of the participant.

Cara walked slowly into my therapy room after consulting me three years earlier during changing life circumstances. Her shoulders hunched and eyes red it was obvious that she had been crying. She had called and booked an appointment, clearly distressed, following the recent death of her beloved father.

Cara is in her early thirties and well qualified. She is always well groomed, and dresses professionally. Her petite figure belies her strong character. I was taken aback at how frail and sad she looked when I saw her, her face pale and eyes dark and sad, she seemed lost and in shock.

When Cara's father died she *"fell to pieces"* in her own words. The shock was overwhelming to her and she barely ate, couldn't sleep and couldn't go to work as she couldn't concentrate or stop crying.

*"I have never felt so lost and alone in all my life."*

Because her pain was so raw and her emotional state so fragile, we progressed slowly and gently as we peeled away the layers in our therapeutic conversations.

## **7.2 Deconstructing the Problem and Mapping Influences**

Biggs and Hinton-Bayre (2008) cite Monk, who in 1997 developed a seven-stage approach to applying Narrative Therapy. Taking apart, or deconstructing the problem – is the first stage of Narrative Therapy, and in this time, the therapist asks questions in an attempt to get the client to explore various dimensions of the situation and to reveal underlying assumptions. Of course, therapy is fluent and attentive to the needs of the client, and the authors warn that these stages are not a formula or recipe, and that strategies can differ significantly from client to client.

According to her direct head at work who called me during her early therapy, Cara is well respected at work, where she has been for many years, consistently moving up through the ranks. Her company granted her quite a bit of leeway after her father's passing, as Cara found it difficult to complete full working days.

The youngest of four children, Cara was always very close to her parents, especially her father. She was probably seen by her siblings as indulged and spoiled. Cara describes her childhood as one of close ties between family members in general, but with undertones that were less pleasant. Both her parents consumed alcohol regularly and became intoxicated. She also knows of affairs both her parents had, each one blaming the other for "*starting first*". Remembering back, she recalls her mother getting "*ready to go out*" for the afternoon and packing a bag, while the teenage Cara looked on and was caught between keeping secrets versus telling her father, risking trouble. She felt she carried too many secrets, more than she felt was appropriate for her age.

From the outside, family life seemed perfect, with her parents often acting lovingly towards each other in public. In private however, things were quite different and screaming matches between them were common. Her father, although a loving parent and "*a really good man*", abused alcohol regularly.

Cara's relationship with her siblings was not very close, as the age gap between them caused the elder siblings to be close to each other, and herself emotionally closer to her parents. She recalls however how she was ordered to make her elder brother's bed in the mornings when they were young. Cara felt a distinct difference in the expectations of girls from boys. She surprised everyone when she studied at university after school and became a successful professional woman.



During the time of her narrative grief therapy, Cara became romantically involved with a man she had a casual friendship with before. This relationship had a very particular emotional impact in this time – one of comfort, and one reflective of her growth.

### **7.3                   Thickening the Narratives**

After school Cara planned to study veterinary science, and was accepted to the course. Her mother died of cancer in this time, and her father became retrenched after taking too much time off from work to take care of Cara's mother. Because of these circumstances, there was no way to support Cara studying full time, and she let go of her dream, and started working. After a while her father came to stay with her and she took care of him. The role of caretaker was one she frequently adopted, even though she was the youngest. This is a role she still slips into quite naturally, one we re-examined in our many therapeutic conversations.

Cara studied part-time whilst working, and completed a degree, as well as further courses. She became financially independent, yet a strange co-dependence developed between her and her elder brother. He suggested that she come and live in his house, "*a mansion*" according to Cara, while he worked overseas. Her brother suggested that she take over some of the caretaking and expenses, for the "*privilege of living in luxury*". Looking back, Cara regrets this decision deeply, as she lost not only a lot of money without having an asset to show in the form of property after the years, but her brother's influence grew stronger, an influence that was not healthy and often bordered on paranoia and contained frequent recriminations. Cara felt like she was being controlled and manipulated to do too much in terms of taking care of her brother's property. However, the strong caretaker role she always adopted kept her tied into the arrangement through feelings of obligation and guilt. As therapy continued, Cara started examining ways of relating that have brought her much anguish through the years. This was most dramatic in Cara's emotional emancipation from her brother and the reshaping of this relationship to a more equal one.

Cara lost her mother at the start of her adult life. This loss had a profound impact on her development as a young woman, as well as on her family dynamics. When I met Cara three years before, she was still trying to make sense of the undercurrents of the 'new normal' in her family. At the time the focus of her attention was taking care of her father with whom she lived at the time. During our new series of therapeutic conversations, the complex and often covert forces at work among her siblings took her attention again. In the midst of her grief she also struggled with disillusionment, disappointment and shock at decisions and judgements by her siblings. As often happens after a passing, old familial patterns are repeated and old roles acted out. Cara's family crisis developed in this time precisely because she aspired to change the roles she played so long - particularly the role of caretaker, the role of youngest daughter, and the role of a woman in a previously fairly chauvinist system.

During the later stages of our conversations, the loss of her mother was discussed more, and the impact it had on Cara's life. Cara felt she was in a male dominated environment after her mother's passing. As the youngest daughter she felt the need to "*be tough and strong*". Yet looking back she can see how she missed her mother's guidance with dating and how to behave as an adult woman. Like her father, her mother died from cancer, but with her mother Cara remembers the illness and final stages as less harrowing. Cara and her mother were not as close as she was to her father, and as a young woman with a father who could make the decisions and take care of his wife, she wasn't so involved in dealing with doctors and so on, and could concentrate on their relationship. So, in a sense the loss of her mother was much less traumatic to Cara than the recent loss of her father. She grieved her mother's loss very differently, and remembers conversations she had with her mother in hospital, and feeling sad in the car on the way back home after she finally passed. When a person dies of cancer or a protracted illness, loved ones sometimes have time to say goodbye and a fair amount of anticipatory grief takes places before the person dies. It is a strange mixture of hope and despair – sadness at the inevitability of the passing whilst still being able to pick up the phone and call them.

When Cara's father died she felt that she had been orphaned by losing her second parent. Suddenly, she felt she had to fend for herself and it seemed just too overwhelming. Her father wasn't there to shield her from her siblings who seemed to be quite jealous of the close relationship she enjoyed with her father. The tough exterior she worked so hard at creating began to crumble.

#### **7.4 The Loss**

When Cara booked her first appointment, her father had passed away of pancreatic cancer less than two months before and she was in the acute first phase of grief. She was extremely distressed, weeping uncontrollably and feeling overcome with sadness. Cara missed her first appointment, made another one, missed that one too, and then at last came at the time we set up for a third. The shock of his passing, the way that her father had suffered in the end and the loss of his company was almost too much for her to bear. The extreme pain seemed devastating, just too raw, and her grief completely disrupted her life. Shortly after our first therapeutic conversation, Cara was hospitalised. She had developed pneumonia and the loss and sadness had completely exhausted her. Various authors have mentioned the effect of grief and the accompanying stress on the immune system (APA, 2006. Gray, 2012).

Cara was in hospital for two weeks. Her feelings of anguish and despair were so acute and intolerable she thought she would never heal. She felt unable to cope with life and its demands, lost her appetite, couldn't sleep, and felt helpless, hopeless and lonely. The world was rushing by as normal but Cara felt unable to get on the merry go round and laugh and participate. It was only after Cara's discharge from hospital that grief therapy could begin in earnest.

Zisook and Shear (June 2009, p. 70) write “First, grief is not a state, but rather a process. Second, the grief process typically proceeds in fits and starts, with attention oscillating to and from the painful reality of the death. Third, the spectrum of emotional, cognitive, social and behavioral disruptions of grief is broad, ranging from barely noticeable alterations to profound anguish and dysfunction.”

Certainly this was very true for Cara who was living through one of the most gut-wrenching and painful experiences a human can go through. Bereavement must be the most difficult emotional experience for most of us. Interestingly, the feelings that characterise it often come in waves with breaks of almost normality in between. Where at first the numbing daze of shock is most profound, when the feelings come back they come in waves. In the beginning the waves are harsh and tall, crushing one under a weight of pain and anguish, mercifully the waves gradually become less frequent and less painfully overwhelming, and eventually a memory may bring only a bittersweet teary smile.

Klopper (2009) describes the waves of grief as a slowly upward winding sinus curve with symptoms such as confusion, lack of concentration and memory loss, loss of joy and interest, weepiness, anxiety, fatigue and weight loss.

After all the medical intervention that this family has experienced, I was very cognisant of the need for the therapeutic process to be respectful and collaborative (Anderson, 1997; & Hedtke, 2000), and for the necessity of the pacing to be established by what she felt comfortable with.

Cara tried to keep a brave face. Her thoughts were preoccupied with memories of her father, particularly of his last weeks. These thoughts and the accompanying sadness seemed to seep into every waking and sometimes sleeping moment. Sometimes she would wake from an exhausted sleep with a cry before she had time to open her eyes, as the awful thought struck her awareness. Unfamiliar dysphoric emotions like regret,

anger, emptiness, nervous free floating anxiety and utter, desperate sadness filled her days and dreams. It is important for a therapist to allow the grieving person to freely express these feelings and reassure them that it is normal, as I did with Cara. The grieving process in itself can be quite scary to go through and it is not uncommon for people to wonder if they are crazy or if they will ever heal. Normalising the experience can be a great relief.

During our second conversation and the first after her hospitalisation, I encouraged to express as clearly as she felt natural all the many emotions she was experiencing, giving them a name and a story.

*“This one is all over me, its name is sadness. It tells a story of how much I miss my dad.” “This one is loneliness, it sits in the pit of my stomach, it reminds me of how empty my life is without him, how quiet it is around me.” “This one is... hmm, I think it’s guilt. It tells me I wish we could have done more. It’s not always there, but when this one comes it’s the hardest to bear.”*

It soon became clear that her grief consisted of different elements: the shock of dealing with the physicality of her father’s illness and passing; the many different undertones of resentment and suspicion among her siblings; coming to terms with what ‘death’ means; and finally, the loss of the companion and friend she had in her father.

## **7.5 Facing the Physicality of her Father’s Illness**

Cara recalled every vivid detail of her father’s last months. She could describe the smells of the hospitals, the sounds of the ICU, the way her father’s body smelled and looked, and the distress he was in. When she went to visit a friend in hospital about 6 months after her father’s passing, she was distraught and upset for a day or two as the memories came flooding back. The worst part of dealing with this traumatic time was seeing her father’s suffering. It *“broke my heart”*. A strong man who often laughed, loved his music

and dancing, and carried her on his shoulders as a little girl, was lying helpless and in pain in a hospital bed, at the mercy of strangers.

Her father had an operation a month before his passing: Whipple surgery, which removed not only his pancreas but a part of his intestine and his gallbladder too. He seemed to recover well, though *“the doctors had told us he only had a “50-50% chance of survival”.*

Soon after his operation her father’s drain came out during physiotherapy. The doctors felt it didn’t matter, but her father took a turn for the worse, and his abdomen began swelling. A second operation followed which was supposed to be a quick, routine draining of the fluid. It turned out to be too much for his body to bear, and his health rapidly deteriorated from then on. Cara is convinced that it was negligence from the hospital’s side, though she didn’t have the strength to sue them. This anger was confusing to her as she was expecting to only feel sad, and yet grief has many faces and many stories.

Cara described in detail one of the scenes in that time:

*“My dad started to become delirious. I don’t know if it was because of the cancer or from the morphine they gave him. The nurses thought he was confused and treated it as a bother. They didn’t have time to talk and reason with him. My dad wanted to walk out, but mostly, he wanted to die. He kept pulling off the oxygen. He begged me to let him die, he was in so much pain. (weeps softly). At the end, he put the oxygen monitor that was on his finger, on mine, begging me with his eyes to take his oxygen mask off. It was unbearable. But it was not my place to let him die, I could not play God. I said to him: ‘God gave you your life, God will let you die when it is your time’.”*

Her father became confused, and started thinking that it was about twenty years earlier. Cara believes it was not just because he was delirious, despite the doctor calling it 'ICU-syndrome'. ICU-syndrome or ICU-psychosis is a temporary psychotic phase characterised by hallucinations, delusions, disorientation, agitation, paranoia and restlessness. It is believed to be caused by the conditions a patient experiences in ICU such as being gravely ill or in shock, sleep deprived, being in an unfamiliar environment and feeling completely at the mercy of others, pain and medication side-effects. (Welker, M. n.d.) Contrary to the view of the doctors who were taking care of her father, Cara's belief is that her father started experiencing flashbacks of his life in preparation for passing. It was also in this time when her father started 'seeing' her mother who had passed away ten years before, standing behind Cara. Her father described feeling 'torn between two forces'. Cara wryly smiled *"I realised I had to release my dad, I couldn't hold him back."*

*"Shame, my poor Dad! He really just wanted the suffering to end. Then they tied his arms, they tied them to his sides, so he wouldn't be able to pull off the oxygen mask. They tied him to the bed with leather straps like they do in a lunatic asylum. Once they bandaged his hands which was even worse for him. I felt they wanted to keep him alive, to make money from him. So he was in hospital and in prison. He couldn't move, he couldn't take his life. It seemed so harsh, I felt so sorry for him!"*

Seeing her father's suffering caused Cara to oscillate between hope and despair. Her father received blood transfusions every day, and was kept alive despite developing pneumonia and eventually organ failure. Cara eventually instructed the doctors to stop keeping him alive and in pain, and to give him only morphine for pain relief. Two days later he died. Cara asked for confirmation from me whether she made the right decision.

*"I couldn't let him suffer so much anymore, you know?"*

Of course, I could not confirm that it was the correct decision, but I did agree what a harrowing decision this must have been to make, and that I'm sure she tried her best to act out of love.

After her father's passing, as is the custom in her family, Cara and her siblings washed and dressed his body for the funeral. She found this extremely distressing and was horrified at the wounds and blood she saw on his body. Her father had long vertical cuts on his abdomen from his operations. This image stayed with her for a long time, overshadowing the image of her father as the healthy dad he had been before. In therapy, helping her overcome the trauma of the experience of this time was the first priority.

## **7.6 Re-Authoring the Grief-Experience**

As a Narrative Therapist, I viewed my task at this time as *collaborator and co-author* of this story. We would look together at this traumatic time, and Cara would not feel that the burden of her memories was her own. Together we would partner to understand, and lessen the frightening emotions that surround the memories. By 'collaborating' in the process of understanding what took place, Cara had *an ally*, and the grief experience could be shared. Cara quite clearly experienced relief from sharing her "*horrible memories*", stories she did not feel was appropriate talking about with anyone. She felt guilty saying that her father smelled sick and cancerous, yet the voicing of her inner thoughts and shock at this provided an almost cathartic relief to her:

*"You know, I've never told anyone this, but my Dad didn't smell like my Dad. He smelled sick, you know? Like cancer. It was horrible. I loved him and wanted to comfort him, but sometimes it was hard to go close to him."*

Creating the safe space for her to express her thoughts and emotions, even those she might find shocking, is the prerequisite for healing to take place. By the same token,



learning that her emotions are natural and therefore nothing to feel embarrassed about relieves her of the added burden of guilt about her thoughts.

Cara's initial emotional distress hinged on the shock of memories of her Dad's suffering. She was traumatised by the hospital experience, by the suffering he endured; by the way the father she knew and loved was reduced to a patient full of tubes and needles, hardly capable of doing much, hardly capable of thinking clearly, simply overwhelmed by the cancer that was ravaging his body:

*"I couldn't believe it was my Dad lying there. He was always tall and strong, and suddenly he looked so vulnerable and sick. I knew it was my Dad, and sometimes I could still see a spark of the old him, but he looked so awful."*

This shock and trauma that Cara was experiencing first had to be acknowledged in a gentle and compassionate way.

There are no magic wands in therapy. Sometimes the most soothing salve for a broken heart is to sit with somebody and provide a comforting presence and kind words. At this point, glib statements and religious sentiments are often unhelpful. Braam Klopper (2009) discusses 'being with' the person, listening without judgement or corrections, and encouraging expression of feelings through open-ended questions. Klopper emphasises that trying to shield a bereaved person from the reality of the situation by avoiding the topic or minimizing the pain is not helpful in the healing process. For him, well-meant euphemisms such as 'he is sleeping' or 'he is better off now than when he was here' make a bereaved person feel misunderstood and may lead to the bereaved keeping their innermost horrors and wailings to themselves, leading to an even deeper sense of loneliness. A better way to approach a person with a recent loss, according to Klopper, is to acknowledge how horrible the experience must be through sentences such as 'I cannot imagine how painful this must be for you, I'm so sorry you're hurting'.

I believe psychologists and counsellors should never forget that they are fellow human beings on a journey with others, also their clients, first, then clinicians. Responding with *narrative empathy* builds not only rapport, but also trust and a space to honestly express even those feelings a bereaved person may be afraid would shock another, without fear of judgement. This compassionate space permits the bereaved person to explore their failings and their strengths, their finest moments and their worst, and grow through fostering the qualities of themselves that they have come to appreciate most. *This is how growth through the process of bereavement takes place.*

Cara was given the opportunity to tell the story of her grief and how it affected her. She was not rushed, even when she cried and sniffed without saying a word for minutes at a time. Slowly but surely we could tease apart the jumble of emotions that lay heavily on her heart. Unravelling the many emotions slowly I hoped might bring some relief and clarity. Of course, sadness and loss were the most obvious and prevalent emotions. She missed her father incredibly, painfully.

*“He was my life partner, no boyfriend could get close, they all told me that (smiling wryly). I confided in him, he was the first one I’d call when something happened. I went to him for advice. He was my best friend, I miss our talks terribly!”*

Because she felt an emotional distance from her siblings in this time, another very difficult and pervasive emotion was loneliness. In this time my most important task was to be an ally who could be with her in this lonely time. I encouraged Cara to write emails to me throughout the week between our sessions, which she did. This became a chronicle of her grief journey, her therapy and ultimately her growth. *Writing is very much a Narrative Therapy therapeutic tool*, but in this time, it was also hoped that it would alleviate the desperate loneliness. Of course, later on in therapy, Cara’s relationship with her siblings had to be discussed, as well as her connection to her greater community.

Cara struggled with confusion which was emotional, rather than factual. In fact, in her intelligent and detailed way, Cara collected medical information as best she could. The advent of the internet has changed how postmodern humans gather information about a variety of subjects, and when a loved one is hospitalised it is quite common to Google every diagnosis and treatment. Sometimes this brings great relief in understanding better how their loved one is cared for. Sometimes this brings a sense of 'they're not doing enough or doing it correctly' with the accompanying frustration. Very often a grieving person's anger is directed at the medical personnel. For Cara it was no different. Questions such as "*why did they (the doctors) not react sooner when his drain came out?*" plagued her. Cara felt some of the hospital personnel were uncaring and money-driven. As her narrative therapist, it was not my place to deny or encourage these thoughts. It was however very much my task to acknowledge and normalise the feelings and how difficult it must be to have these thoughts and feelings in a time like this. Interestingly, as soon as I acknowledged this to Cara, the anger seemed to dissipate almost immediately. She just needed someone to hear her about this.

Cara struggled with guilt that's seemed to "*sneak up on me at night*". It was an opportunity to use the image of 'sneaky guilt' to *personify the problem*, aiming to bring a new perspective on it. White & Epton (1990) very strongly believed in the insight that *externalising and personifying a problem* brings, as well as relieving the client from the identification with it. So, instead of 'I feel so guilty' a client may examine 'guilt as a bad guy' that can wreak havoc. This frequently facilitates the release of the emotion and is often coupled with some humour, lightening heavy emotions.

Cara and I discussed when '*sneaky guilt's voice was the loudest*'. She realised it happened mostly at night, especially following conversations with her sister. We pondered if there were anything more she thinks she could have done. After a long silence, she responded that she thinks she probably did as much as she could. She followed her answer with "*I guess I just feel so sad that my poor Dad had to suffer so*

*much...*”, to which I responded “yes, it truly is very very sad”. It seems the guilt was really just another face of the sadness.

Not long after commencing our series of therapeutic conversations, Cara sms’d me on a Friday evening that she is very depressed and weeping uncontrollably. When I called her a little later, she confessed to having gone through “*a bit of a dip*”. She had put on her father’s pyjama shirt, sat in his bedroom and surrounded herself with mementos and things he loved, his CD’s and books. Then she took a number of her father’s painkillers. The analogy of needing to kill the pain is clear, and the play on words was discussed in the next therapy session, in true Michael White style. Fortuitously she became nauseous from the pills, and suffered no serious side physical effects. This immersion in pain and grieving was a turning point for Cara:

*“I just wanted to die, Marie-Jeanne, to be with my Dad.”*

But she didn’t take enough painkillers to end her life, and the mixed feelings around this could be discussed. Was she going to choose to live? After this Friday evening, Cara made a choice – she wanted to live, and she wanted to make the best of her life.

## **7.7 Searching for an Alternative Story - Identity Growth as New Ideas about Death develop**

This was the second time Cara encountered the death of a loved one. Her mother had died when she was in her final year of high school, dramatically changing the course of her life. She was of course much younger then, barely an adult, and the loss of her mother with whom her relationship was different to that of her father’s was experienced very differently.

Her father’s passing seemed to her to be an especially harrowing one. She was faced with much suffering, hospitals, nurses, doctors, the smells and sounds of ICU, and a body that slowly languished.

For some people, their spirituality can be a great source of comfort. Cara grew up in the Catholic Church and tradition. The concept of life after life was a given to her, and provided some answers and comfort in the losses she had to face. Cara's faith had changed through the years and with her father's passing the focus had shifted to a more spiritual approach. Cara often told me that she felt her father with her after his passing and felt that she was getting signs from him, especially in the form of repetitive numbers that she would come across. About four months after his passing, Cara visited a medium who seemed to confirm many of her thoughts that her father is 'around' her. This concept brought her much comfort.

Dying as an experience remained a concept filled with some fear for Cara. This, I believe, is natural and probably ensures our survival (and prevents contemplations of suicide as she did before). Unlike the time after her mother's passing when Cara relied on her faith in Heaven to pull her through, with her father's passing her own subjective experiences of his spirit presence relieved her feelings of loneliness and despair and brought her a sense of peace.

Calhoun and Tedeschi (2000, p. 167) explain that religious and spiritual beliefs have been observed to be one way in which individuals create meaning and a sense of order and purpose after the experience of trauma. The collaborative and respectful approach of the Narrative Therapist in enquiring considerably about the mourner's worldviews, including how they may have changed during the grieving process, accesses the client's deepest meanings about life and death, and can explore further sources of comfort for them. In Cara's grieving process, she often remarked how much she has grown, how much deeper she seems to be thinking about philosophical and spiritual issues, and how much this has helped her to think of her father's death as not senseless but meaningful. She has discovered a talent for intuitively feeling things, one she wasn't aware of before his passing. By the time therapy concluded, Cara was playing with the thought of exploring this further through intuition classes.

From the careful exploration of her spirituality, more existential questions came to the fore. Cara asked herself “*what is the purpose of my life?*”, “*why did I go through this experience?*” and “*what is the meaning of this life experience for my relationships, and for my future?*” These questions were fully explored towards the end of therapy, and brought the greatest amount of growth. Cara discovered that she is naturally a care-giver. Although this has not always stood her in good stead, being aware of this personality trait, and steering it consciously, it was hoped would lead to more of a sense of fulfilment in life.

## **7.8                    Saying ‘Hello’ Again**

It was clear that the pain that Cara was continuing to suffer was because of the feeling that her father was gone from her life and that she would have to face life without his presence in it. That seems to be a statement of a fact, rather than an interpretation. If we consider the aim of grief counselling since Freud’s time: the concept of needing to ‘say goodbye’ and ‘move on’ was considered to be the core of the healing from grief as a malady. For the past century or so in the West, the purpose of grief was seen to reconstruct the autonomous individual, who, in large measure, leaves the dead person behind. “Grief is conceptualized as an innate process that, if allowed to run its course, will bring the survivor to a new equilibrium in a changed world that no longer includes the dead person.” (Klass, Silverman & Nickman, 1996, p. 5).

In fact, “The view of grief most accepted in this (the twentieth) century holds that for successful mourning to take place the mourner must disengage from the deceased, and let go of the past... To experience a continuing bond with the deceased in the present has been thought of as symptomatic of psychological problems.... A continued attachment to the deceased was called unresolved grief.” (Klass et al., 1996, p. 4)

Cara quite naturally resisted the idea of excising her beloved father from her life:

*"I cannot fathom a world where he is not a part of my life. My Dad was always there, always. I don't want him out of my life. This is breaking my heart!"*

Michael White (1988), co-founder of Narrative Therapy, in his article *Saying hullo again: The incorporation of the lost relationship in the resolution of grief*, pleads for a radically different approach to grief counselling - one where the deceased loved one remains very much a part of the on-going life experience. He worked from the principle that this is not just kinder and more natural, but also that it could lead to less pre-occupation with the loss and greater healing as the deceased person's memory is incorporated in the greater life experience of the bereaved person's social group and identity. He quotes Myerhoff (1982, p. 111): "Freud ... suggests that the completion of the mourning process requires that those left behind develop a new reality which no longer includes what has been lost. But ... it must be added that full recovery from mourning may restore what has been lost, maintaining it through incorporation into the present. Full recollection and retention may be as vital to recovery and wellbeing as forfeiting memories." (in White, 1998, p. 17)

Louise Hedtke (2010, p. 304) puts it beautifully: "...death may be understood from a postmodern perspective, and responded to, primarily as an event in a relationship, rather than primarily as an event in the life of a lone individual."

In this view, the relationship is not over, but changed. The person does not have to do the incredibly painful task of 'cutting the ties'. Rather, reconnection and reincorporation is encouraged as an essential part of healing through Narrative Therapy. "Focusing on what remains, rather than only what is lost when a person dies, has a therapeutic effect because it re-establishes a storied connection to those who have passed." (Hedtke, 2010, p. 6)

Consequently, I asked Cara ‘what would it feel like if you could say ‘hello’ again to your Dad, incorporate him into your life in a new way?’ This was a new concept to Cara who believed and had been told by well-meaning friends to ‘start living again’, ‘move on’ and once even ‘to get over it now, you’ll feel better’. It took a while for this idea to sink in, what if she could maintain a relationship with her beloved father even when he was not physically present? How would that look like?

I explained: ‘Suppose you were told that you do not need to forget. Suppose you could remember your Dad and all the details of your relationship. Suppose you could remember him as part of your group of loved ones. What would that be like?’

*“Well... I suppose it would be a great relief.... I don’t know yet how that would be like, but I can tell you that I like that idea a lot. I don’t want to say goodbye to my Dad, I don’t want to let him go! I understand that his body has died and I miss holding his hand and hearing his voice. Every time I reach out to pick up the phone to call him and remember he’s not there anymore. But if I don’t need to really cut him out and move on... well, I guess that means I can still talk to him. And still talk about him.”*

I suggested that Cara *write a letter to her Dad* about feelings and events in her life as a practical way to express the continued relationship. Cara did that and shared the letter with me in our next conversation. In her letter, she poured out her feelings and experiences, the way she might have done in a normal conversation. Cara ended the letter:

*“I miss you Dad. Every day. But I take comfort knowing that you are out there, happy and with Mom. And knowing that your pain has subsided. I know you are with me and I find solace in that.”*



It seems that having permission to continue a relationship with a deceased loved one is enough to provide a sense of relief and a softening of the 'I ought to be stronger' narrative that very often pervades a grieving person's thoughts. Whatever shape this on-going relationship takes is up to the person and often depends on their unique character, their relationship before, and rituals the bereaved person develops to remember their loved one. For Cara it took the shape of frequent conversations with her dad through letters or whilst driving, 'telling' him about the details of her life. Sometimes she would wish for guidance, and drawing on previous strengths explored in our conversations, come up with solutions herself.

### **7.9 An Alternative Story Found**

'You have experienced so many sad moments and have told me of many upsetting moments in the hospital. Were there other memories in this time, memories that were perhaps poignantly beautiful or even humorous?' I asked. This was done to *'thicken the narratives'*, a core technique employed in Narrative Therapy. Yes, indeed, many soft moments took place between father and daughter, and Cara felt that she had time to say goodbye to him while her father was alive. She smiled when she remembered how her father at one point became convinced that he is twenty years younger. He kept saying he needed to get back to work, and asked after people who were long dead or now much older. Cara laughed at the quirky sayings coming out in this time, and the references to work and colleagues that were no longer relevant at all. She remembered her humorous indulgence of her father's stories at this time. Lorraine Hedtke (2000, p. 4) agrees: "Even in the midst of what appears to be tragic, I assume that something good can be born. There are still many possibilities for laughter and love in the presence of death and pain."

### **7.10 Re-Authoring the Grief Experience in Alignment with an Emerging Identity**

"In striving to make sense of our lives, we face the task of arranging our experiences of events in sequences across time in such a way as to arrive at a coherent account of

ourselves. Specific experiences of events of the past and the present, and those that are predicted to occur in the future, are connected to develop this account, which has been referred to as a story or self-narrative.” (White, in White & Denborough, 1998, p. 22) and “The structuring of a narrative requires recourse to a selective process in which we prune, from our experience, those events that do not fit with the dominant evolving story that we and others have about us. Thus, over time, much of our stock of lived experience goes unstoried and is never ‘told’ or expressed.” (p. 23)

For the first months after her father’s passing, Cara felt so overwhelmed by grief that to herself, and to some of her family members, her identity had become one of a weak and psychologically unstable person. In one of her letters to her father Cara wrote:

*“The depression and loss I felt after you died, is hard to explain. I reached the darkest place I’ve ever been to, it was scary and sad and I never want to go back there again.”* In another letter *“I weighed 41 kgs when I booked myself into hospital.”* and later *“I felt like the family pounced on my weakness and I was suddenly the ‘mad one’ in the family because I went on antidepressants and started therapy.”*

It was crucial to ‘*thicken the narratives*’ to include moments when Cara acted courageously and with emotional strength. Many conversations followed where we explored times of resilience such as when her mother was sick with cancer and dying, and Cara continued her schooling and passed her matric well. We also explored the resilience and determination she had shown to study part time after school whilst working. More recently, she was the sibling who took her father to most of his medical appointments. She continued working and according to her manager remained a valued employee throughout her father’s illness and hospitalisation. During the time of her therapy, Cara also had to deal with rather hurtful remarks and behaviour from her siblings, it astounded her that they could be so callous in this time. She tried her best to act wisely and calmly and it often formed a part of our discussions.

I pointed out to her that she was often quite strong and unexpectedly resilient in this time. This shows *exceptions*, not just in the lived time, but in her character. Monk (cited in Biggs and Hinton-Bayre (2008) calls these exceptions ‘sparkling moments’. Meeko (2002, p. 98) notes “The overriding goal of the therapist in the stage of deconstruction is to slightly shift or loosen the hold of an old story. Every inch that the dominant story loses becomes acreage on which to build a new narrative.” These exceptions could be drawn on as Cara shaped a new identity through the grieving process.

Freedman (Freedman & Combs, 1996, p. 36) writes that “the key to this therapy is that in any life there are always more events that don’t get ‘storied’ than there are ones that do—even the longest and most complex autobiography leaves out more than it includes.” It is the task of the Narrative therapist to help the client remember sparkling moments of strength, resilience and courage.

I asked, ‘if you could see yourself through your dad’s eyes now, what do you think you would notice about yourself that you could appreciate?’ Cara became quite emotional:

*“No, they’re happy tears! My dad always said he was proud of me. I think my dad would be proud of how I handled things with the family, that I didn’t become nasty but I also wasn’t a push-over. I think he would like that I am back at work and slowly packing up his stuff, even when it makes me sad. I’m sure he would like it that I’m playing his records and keeping his memory alive!”* she smiled through the tears.

Michael White in his 1988 article lists a number of possible questions to ask a bereaved person to thicken the narratives and shine light on forgotten strengths that could be celebrated in the identity that continues after the grief. “I believe that those questions that invite persons to recount what they perceive to be the deceased person’s

experience of them, achieve this simultaneity. In this reaching back into experience, alternative and previously lost knowledges can be located and re-performed. Thus, new and enriching acknowledgements and validations of self can become available to persons.” (White, 1998, p. 23) Hedtke (2000, p. 6) agrees: “my inquiry was both pragmatic and intended to access her unwritten stories about her own courage and strength. This form of conversation calls forth from people their ability to rise to the occasion, to handle things they did not know they could. Life will go on for Ellen in some fashion. My concern, even in my brief contact with her, was about the calibre of experience that she would draw from as she went forward in life with these circumstances. How could I increase the likelihood that Bill’s dying process would include positive things she could reflect upon and utilise to reinvent her relationship with her husband? My questions were about asking her to step into an ethical position of caring for her own resourcefulness through enhancing her story of herself as a person of calibre, courage and resiliency.”

### **7.11 Resolution**

As often happens in life, we seldom have the luxury to experience one emotional thing at a time before another comes our way. In the midst of grieving Cara became closer to a man she had previously viewed only as a friend. His support meant a lot to her and she fell in love. I learned later that they had married and that Cara was pregnant with a little boy, whom she intended naming after her father.

I knew therapy was over when I read what Cara wrote eight months after her father’s passing in a letter to her father:

*“I feel stronger, healthier and happier than I have in a very long time. I carry my memories of you with me and I aim to live a life that you would be proud of, instilling the morals and values that you taught me in life. I left behind the glitz and glamour and settled into a normal life, because let’s face it, I realised when you were dying, that money means nothing in the bigger scheme of things. I am*

*giving back, helping others where I can because I believe that is one of my bigger purposes in life. And I'm starting studying in July, finally going to get my honours degree... I'm sure you're smiling wherever you are."*

It was clear that Cara had healed from the emotional anguish, had grown through the grief experience and emerged with a new identity, and had a continued positive relationship with her beloved father which she incorporated quite naturally in her new life.

## Chapter 8

### Linda's story: Dis-covering resilience through the loss of three mothers

*"For whatever we lose (like a you or a me),  
It's always our self we find in the sea."*

~ E. E. Cummings (2007, p. 6)

#### 8.1 Personal Data

Participant:	Linda
Age:	Mid fifties
Field of Occupation:	Nursing
Education Level:	Higher Diploma and further relevant qualifications
Therapeutic Setting:	Psychology private practice
Language:	English
Therapeutic Conversations:	15

\* In the final report names and some identifying particulars were changed in order to protect the identity of the participant.

#### 8.2 Introduction: Lasting First Impressions

I remember hearing Linda's voice the first time she called for an appointment, a deep yet feminine distinctive voice that gave the impression of a woman with strength of character, calmness and sadness all at once. There was so much already of her personality there in the few short sentences it takes to book an appointment. I suspect that is Linda's way - to touch the lives of people she comes into contact with, I was one of the fortunate ones that had the opportunity get to know her better through the months to come.

Linda's is a middle-aged woman who takes great care with her appearance and is always understatedly elegant and feminine. Her face, though serene, has lines of sadness around the eyes, as if she had lived through many emotional upheavals. Always dressed for our Saturday morning sessions in tasteful feminine semi-casual wear, Linda projects a sense of calm acceptance. Her voice is even and slightly deep with a touch of weariness and sadness. As she talks, she sighs frequently which strengthens the impression of weariness. Linda is mostly quietly composed; she tears up only on occasion, particularly when she talks about her grandmother.

Linda suffered three losses in close succession, all three of her mother figures, all three of whom she loved deeply. Her mother died the previous November from Aids, almost a year before we met that October. Her great aunt died in June, and her grandmother with whom she grew up died in July. For Linda, by far the greatest and also the most complex loss was that of her grandmother with whom she spent most of her childhood years. In our talks she called her grandmother either "my granny" or "Gogo", the isiZulu word for grandmother.

### **8.3 Mapping Influences**

Linda grew up with her grandmother in Soweto in the seventies. Soweto at the time was of course much smaller than today, but it was still a large settlement of people with a unique culture adjacent to and part of Johannesburg. It is home to Chris Hani Baragwanath Hospital, purported to currently be the third largest hospital in the world. Soweto is of course also the place where the Soweto Uprising took place in 1976 which changed the course of South African history. Linda and I never discussed politics and it didn't seem to ever be an issue, despite our different cultures, childhoods and skin colour. Politics didn't seem to matter, it was only a meeting between two women where one was in pain and another supported her and had the honour of sharing a part of her healing journey.

Throughout our conversations, her relationship to her family members, particularly female members, came up quite often, as her grief story is very much seated in her family experience. Of particular importance was her grandmother's strained relationship with her sister, Linda's great aunt. Linda's relationship with her sisters was also fairly disconnected, as they grew up with her mother and she herself with her grandmother. In general the sense was that the females viewed each other with a sense of distrust, and though family seems to be important to all of them, the relationships among the females were often characterised by allegiances, wariness of other groupings and an uncomfortable togetherness at family gatherings.

Linda is married to a man she feels disconnected from. They seem to have very different outlooks on life and Linda felt that he didn't know how to understand or support her in her grief. As the months passed, she considered leaving him because she found the constant put downs and the awkwardness at home sapped her already low energy. Her husband seemed disinterested and distant to her, and at times she got the impression he was possibly jealous. After work she would come home and they *"had nothing to say to each other."*

Linda never had children of her own but because of her naturally nurturing nature she often adopted the role of caretaker in her family, especially of the older generations.

Linda is a specialist nurse and successful in her career, and very well regarded by her colleagues. During the time of our conversations, she often talked about feeling terribly exhausted, a common feeling for grieving people. She felt like she didn't sleep deeply and didn't awake refreshed. She often had vivid dreams. Although she loved her work and always has, she found herself overcome with what she described as a mental tiredness. For the first time she found herself with less patience with colleagues, especially when she felt that they were hung up on petty concerns. She found the small niggles so unnecessary, as she mentally struggled with things that seemed so much more



important. To add to her exhaustion, her career required her working long shifts of sometimes more than twelve hours. Sometimes she felt that she was just:

*“treading water in my job, just hanging in there.”*

#### **8.4 Thickening the Narratives of the Loss**

##### **8.4.1 The Passing and Burial of her Mother**

Linda’s mother died on a Sunday morning in November from AIDS. She was called by the family to come, and a sense of calm enveloped her. She knew that it was a matter of time, as the previous night she wondered if her mother would make it through the night. Linda told her family to make her mother comfortable and prop her up a bit with a pillow. She died before Linda could reach her.

The fact that she wasn’t with her mother when she died, didn’t bother Linda. She felt a sense of peace and acceptance (which contrasted with the feelings she had as a child of battling to accept her situation of living away from her mother). At one point she wistfully said *“I missed out on being raised by my own mom.”* But she had come to accept that fact through the years. Linda’s mother was buried the Friday after her passing.

Whereas Linda’s family had always handled funerals collaboratively before, she felt that her aunts (her mother’s sisters) stood back and let her handle all the preparations. She felt that she was expected to fail.

Linda became numb:

*“I just woke up in the morning and started doing things. I would eat lunch in the car. I didn’t cry, I just did.”*



She was expected to make the calls to family and friends to inform them that her mother had died. She organised the whole funeral, though when people came to her mother's house, she was mostly quiet. It is clear that at this point she was still in the first shocked phase of disbelief that so many people find themselves in after the death of a loved one.

The funeral *"was lovely."* Many people came, and it was characterised by numerous testimonies of her mother's generosity and helpfulness.

*"Some said if she only had a last piece of bread, she would share it. Even children spoke about her as 'Sisi', sister. Everyone loved her. She touched so many lives."*

Linda was stunned to hear about this aspect of her mother's character and how loved she was. It contrasted with how she thought of her mother when she was a child, when she felt bewildered and let down by her mom and raised by her grandmother. Linda kept quiet at the funeral, even though she was the daughter who organised everything. I asked what she would have said if she were to have made a speech at the funeral.

*"I would have said that I am so grateful that I had the chance to get closer to my mother before she died."*

The Friday afternoon after the funeral Linda collapsed from fatigue at home. She was spent after having taken care of all the people who came to her mother's house, and all the preparations. At last she could be quietly at home. She spent the weekend *"being still"*. It was weeks after her mother's passing before she allowed herself *"a good cry"*, and felt better for it.

While Linda narrated the story of her mother's passing, she noted how alone she felt:

*"I had a picture of myself standing alone, I still needed her, I still wanted to tell her things, make her happy by doing things for her."*

This was such a typical expression of Linda's character, as much as she needed her mother and felt the loss of her presence in her life, within the second breath she mentions she wishes she could have done more for her. Interestingly too, she was almost more concerned with how her grandmother, who had lost her daughter, thought and felt. Linda struggled with sadness at the thought of her grandmother feeling sad. I pointed out that it seemed interesting to me that in Linda's mind her grandmother's pain was more pronounced than her own:

*"Well, her pain was always my pain. And my mother's passing was much less upsetting than when my Gogo passed away."*

#### **8.4.2 The Death of Two Grandmothers**

Linda was just slowly starting to adjust to life without her mother in her life, when her great aunt and then her grandmother passed away in quick succession. Whereas she was relatively accepting of the passing of her mother, partially because she didn't grow up with her, the new losses threw her into emotional turmoil. I met Linda three months after the death of her grandmother. Her composed demeanour belied her inner distress. It was as if the carpet was pulled from under her. Yet she approached our conversations calmly and tried her best to remain fairly logical, aiming to understand a complex family (his)story and her own many faceted emotions.

Linda notes this was *"just such an overwhelming experience"*, so many losses and events in a short space of time.

*"I'm drained, I'm tired and most of all I'm scared. Not long ago I prayed to God to give my life to someone who wants to live. I'm longing for peace and happiness and love. Is it too unfair to ask?"*

She brightens a little when she describes her great aunt:

*"My granny's sister, my great aunt was an amazing soul. She died peacefully at home from old age. She was blind in her old age but you know, she was so amazing - she still dressed herself, made her bed and made herself tea every morning. I never knew how."*

Linda found her quite remarkable and inspirational and says:

*"I can still see her smile, it warms you".*

She tells me her granny's sister told them many stories growing up:

*"Perhaps because she was a teacher so she knew how to tell a story to keep a child's interest".*

I encourage her to tell me some of them and with a smile and a faraway look in her eyes she tells the stories her great aunt told about her grandmother:

*"My Gogo was tall and slim and she always walked and sat upright. When she walked into a room everyone noticed her. Not many people knew this about her, but she was quite mischievous actually..."*

Describing her grandmother as a young person seemed to remind Linda of a different perspective of her grandmother whom she tended to remember as an old lady. In this way, it was hoped, Linda could re-member her Gogo as part of the circle of people who loved her, without the old associations and pitfalls of family habits, but as a strong and interesting female who could be inspirational and relatable. It is clear that the stories this family told each other about themselves and their family shaped the fabric of each individual in it. They were clearly quite interconnected and influenced each other greatly. I remarked how many incredible female ancestors Linda has.

It was only in our fifth therapeutic conversation together that Linda told me the full story of her grandmother's passing. In fact, Linda barely spoke about the experience of her loved ones' deaths at all, which was quite dissimilar to the narratives of the other

participants. She preferred to focus on their lives and personalities and sadly, the old family dynamics absorbed much of her attention while she was grieving.

*"The last time I spoke to my granny she was still in a quiet mood after her sister's funeral and the phone conversation was very short. She said to me 'I'll speak to you soon' and those were the last words I heard from her that Friday evening. That Saturday morning she collapsed at home and I arranged for an ambulance and she went to hospital the Saturday evening. I can't explain it, but I felt such a sense of resistance to going to the hospital."*

I wondered what could have contributed to that feeling of resistance.

*"If I think about it, I suppose I must have felt helpless to make any difference, there was nothing I could do to make it better and I really did not know what to do. My granny's children didn't call me with any information about the ward even. This really made me sad and it took a long time just to find out where she was. Couldn't they put their differences aside at a time like this?"*

On the Sunday morning Linda went to see her grandmother for the last time.

*"I knew she was going to die, you just know, you know? I sat with her and held her hand and told her that I love her. I told her it was okay, she could let go, I was not judging her, it was okay. Then I prayed for her and it was as if you could feel a sense of relief. I remember... my Gogo's body felt so tense, and then she seemed to relax... She had had a stroke and later that that day she slipped away."*

## **8.5                    Thickening the Narratives of her Beloved Grandmother's Complex Character**

Linda held her grandmother in very high esteem. She mentioned that our previous session that contained a long discussion about her grandmother:

*"...was a phenomenal session. My grandmother to me is like a light beam, with flowers around."*

Linda says that she always knew she had her faults, but they didn't seem to matter so much before. But then a tenseness started inside as the week progressed and the thought came:

*"How could she? 'I know she had our best interest in mind but... it made me so sad."*

And angry maybe? I suggested. "Yes."

I wondered what brought about these feelings. Linda struggled to find the words, and some more questions followed to tease apart the many strings in the ball of emotions.

*"I've just been so tired from all these emotions..."*

The effective use of questions in Narrative Therapy can facilitate deeper insight, greater self-discovery and improved understanding of hidden dynamics in families. The therapist's role is facilitator and ally, rather than expert diagnostician and "narrative questioning has the intent of uncovering meaning and generating experience rather than creating information." (Freedman and Combs, 1996, p. 97). A Narrative Therapist never judges a client's experience, even experiences that would make another person uncomfortable, such as feeling anger toward the deceased. It is crucial for a bereaved person to know that they have a non-judgemental ally in their therapist who will allow all the facets of their grief to come to the fore.

Linda's anger towards the woman who raised her was disconcerting to her, and she struggled to express it and explain the reasons why. I gently encouraged Linda to describe her grandmother's character, to thicken the narratives. Linda had described her as a complex character who was mostly misunderstood. Her mixed feelings towards her grandmother mimicked the sometimes contrasting characteristics of her grandmother. Linda felt confused and her emotions jumbled, and I thought it would be helpful to tease apart the different aspects of her feelings.

Linda mentioned that her grandmother lived alone, and seemed to be fiercely independent but also perhaps a rather difficult character to live with:

*"I would describe my grandmother, I suppose, as quite a strict woman, you know, no one wanted to stay with her."*

Linda's family seemed to be a bit wary of her grandmother and even if in a pinch, would try to avoid living with her:

*"If you stayed with her, you knew you had to get up at five in the morning, and that the house always had to be neat and clean. My Gogo had very high expectations and she was very organised. She liked to talk and sometimes I think she might have offended people. You know, she called it as it is. Not in a subtle and polite way! (laughs) But you know, I knew and understood her. I think her children thought her strictness meant she didn't like them or their children. She didn't mean to but she pushed people away."*

It took a while for Linda to express her frustrations which mostly had to do with misunderstandings among the women in the family. As she talked, it became clear to her that her grandmother's curt communication style contributed to misunderstandings and distance from her sister. She also understood that her grandmother was quite possibly more insecure than she let on, and hid it under a tough exterior that didn't tell the true story.

Linda had developed a very close bond with her grandmother as she became the most important mother figure of Linda's childhood. Linda made allowances for what others may have perceived as difficult, somewhat annoying character traits, and felt that she knew that mostly, her grandmother was well intentioned. Linda also sensed that it couldn't have been easy for her grandmother to be the way she was, and with Linda's typical compassion, she tried to compensate by giving her more love and loyalty:

*"I think besides my granny's last born daughter, I was the only one who 'got her'. Yes, only myself and maybe her youngest child. And now that I think about it, I suspect she must have been lonely, because of her ways. But I was always there for her, and she could even cry in front of me. I understood her humanity."*

Linda's annoyance and frustration with her beloved Gogo was short-lived. It needed to be acknowledged so that she could forgive her Gogo for her human failings without denying them. And as suddenly as her dis-ease about her grandmother's stubbornness arose, as swiftly it faded into compassion and love.

## **8.6 Grief is Socially and Culturally Constructed**

A lovely narrative about Linda's remarkable family was symbolised in a precious possession - in Linda's family a dinnerware set was passed on from generation to generation, without a single plate breaking or chipping, and still with the gold edge in good condition. It is taken out only at special family gatherings. Linda was very proud to be the owner of something with both real and sentimental value. This set symbolises Linda's family to me – beautiful, fragile and when well looked after, an inheritance of much worth for many generations. In the same way that the set was packed away carefully in paper and taken out when the family members met, the rich narratives of their lives were kept safe and the cherished stories shared when they all got together, laughing, crying and reminiscing about their shared history.

The basis of Narrative Therapy theory is Social Constructionism which is based on the idea that the way people experience themselves and their situation, also their grief experience, is culturally constructed through rituals and meanings built up over time. These socially mediated interactions often pass from generation to generation in families, and become imbued with meaning and expectations.



In Linda's family and culture, a mourning ritual is held signifying the end of the first three months of mourning, as is expected of a daughter mourning a mother figure or sister. The sharing of the belongings of the person who passed away is a ritual that has remained when many others in African culture, such as the ritual slaying of an animal, seem to be fading gradually with Westernisation. For Linda, the sharing of belongings ritual was always a special tradition.

After her Mom's passing, this ritual was very much a ritual of remembrance. There was much laughter and stories told of her mother's life. On that occasion, Linda felt she learned more about her mother, and the shared laughter and storytelling bonded family and close friends. She felt blessed by this gathering. I tell Linda about the concept in Narrative Therapy of *'re-membering'*, when the person who has passed away is remembered with her family, incorporated afresh in the clan of her people. Linda loved the concept and it naturally resonated for her with another African tradition – revering the forefathers. “Within an African context, the dead are regarded as ancestors and they are treated with great respect as they are believed to have a special relationship with the living. Proper rites and ceremonies performed following the death of a loved one reflect this belief.” “Rituals serve particular functions, but primarily, they help the families to accept the reality of loss, to express the feelings related to loss and accomplish the task of grief work.” (Setsiba, 2012. pp. 5, 14)

At the ritual get-together for her mother, Linda chose a dress and head cloth:

*“a real old fashioned doek!”* she laughed, and a dress *“my mother looked so feminine in, so stately, so lovely”*.

At times Linda would wear the 'doek' as she connected with her culture and remembered her mom.

Linda arrived at our sixth conversation somewhat distraught after happenings in her family. By contrast to the sharing of the belongings of her mother, the ritual for her grandmother's possessions turned sour last Saturday and was experienced very differently by Linda. In Linda's family, traditionally all would gather at the deceased house. The belongings of the person who passed away, such as clothes, dishes and so on, are laid out, and all who were invited, mainly close family, are entitled to take whatever they wish. The rest is given to charity or burned.

Last Saturday's gathering had a very different feel: Linda was informed by sms by her aunt, a cool sms sent at night, unlike the usual warm phone call.

*"You know, it wasn't an invitation. It was just come to the house on Saturday."*

This didn't bode well, and gave an indication of the stiff welcome she was to receive on the day.

At the house she felt so ill at ease that she could almost not believe it was the house she grew up in. A large graduation photo of her that used to be on the wall was removed, and when she asked about it, she only received a vague response.

Only her grandmother's oldest clothes were laid out. Linda knew this immediately, as she had bought many of the newer garments, and because:

*"I knew my granny so well, I knew everything she wore, everything she loved, I took care of her."*

Linda knew this meant that the aunts had decided to share the better things among themselves. This saddened her immensely – not because of the material possessions, but because of the open hostility towards her, and the fact that this ceremony which could be one of joyous remembrance was spoiled by antagonistic demeanours and petty greed.

*"I pray that my faith never fails, but it's not easy. I hope that one day the family will all get along and talk about good times we've had. But I don't know, I just don't know."*

Because of the disconnect from her extended family and their barely veiled hostility, as well as the distance she experienced from her husband, Linda found her time of grief a quiet and very lonely one. She felt that she carried the burden of sadness mostly alone, and that no one completely comprehended that in the death of her grandmother, she had lost a *mother*. In her typical quiet, reserved way, she said to me softly one day:

*"I don't think anyone thought or knew... it wasn't just a grandmother, I actually lost three mothers..."*

I was very touched that this composed and unpretentious woman shared so much of her innermost secrets and hidden feelings with me. She had accomplished so much despite her less than ideal background and developed into a courageous, compassionate and genuinely good person. This was a very difficult life experience for Linda that she felt she carried mostly alone.

In Linda's complex grief story, the family relations added to the many layers of complex feelings. Besides sadness Linda understandably also struggled with difficult feelings of anger and disappointment towards her grandmother, and confusion at the less than conciliatory attitude of her aunts. Similarly, her aunts and mother were not always on good terms. Linda was baffled when she discovered that her aunts did not encourage but rather dissuaded her grandmother from making peace with her sister. I reflected the generational pattern of rejecting one sister, in two generations. It left Linda side-lined from the clan of women and family she so desperately wanted to be a part of since she was a little girl. The sadness of never having borne her own children and standing on the brink of losing her marriage made the loneliness even more poignant.

## 8.7 Deconstructing 'the Problem' of Feelings

*"I'm beginning to feel now...moving into the most sensitive state now. Before I would push things away, so now, this space I don't know how to deal with. Feelings come easily ...."*

Linda was soft and sensitive at our seventh conversation. I responded that emotions are normal and important, and though uncomfortable, need to be acknowledged and that I was willing to listen to each and every one of them.

*"I don't know how to deal with it. I don't understand. I'm so tempted to just say 'ag, go away, to my emotions'. It seems like the emotions are now bubbling up and there's nothing I can do about it. And I realise now, I don't know how to deal with emotions."*

Allowing Linda to fully be with her emotions without the cultural, familial and own judgements often subtly imposed was an important step in the healing process. Consequently, we gently explored the origin of needing to keep a lid on emotions:

*"I learned to keep it in as a child and now I don't know what to do. You know, I just had to shh and accept things."*

She describes being:

*"Very very tense inside. Just too many emotions, I can't make sense of it all. I just feel like running away, but of course I won't, and I can't."*

It was very difficult for Linda to be with her feelings and not resort to old habits of denying her heart and not making a fuss.

I comment how brave she was to now let her emotions be naturally there, and continue with her therapy even when it had become so uncomfortable for her to acknowledge that she is overwhelmed. And how very understandable it is that as a little girl who had

to accept that she could not live with her mother, and had to adapt to the strict household of her grandmother, she learned to stay quiet and not express her emotions too loudly.

I enquired if she thinks this habit shaped her into the woman she is today.

*"I've learned to be quiet, to know my place, and to be respectful. This has helped me a lot in my work. I like to be calm and professional. But sometimes I wish I could just cry and be comforted."*

I ask if she could describe her feelings, understanding that Linda has learned to suppress her emotional needs for the sake of others and that it has become a very hard habit for her to break free from.

*"I can't describe it, I'm just upset... I realise now that my grandmother was not always this wonderful saintly woman I always thought. I always thought of her as this beautiful woman with flowers around her. Then I realised... She was not all that. I started analysing things, how she did things, how she died. And it made me feel quite emotional thinking about these things."*

*"I never expected to feel anything but sadness. But I must admit I struggle with anger about her stubbornness, especially her stubbornness in resisting reconnecting with her sister. Her stubbornness killed her, if she had just talked about it she would have been okay".*

And later *"When her sister died I was angry with my Gogo, because she didn't listen to me. I begged her to go to her sister and make peace with her. But she was adamant that she wouldn't".*

*"...but as soon as I talk about feeling angry with Gogo, I feel I'm being disrespectful, and I feel guilty."*

*"About my aunties... I guess I'm just numb. It seems I'm the most upset at my Gogo. I didn't expect that."*

To normalise all the many faces of grief is very comforting and I explained to Linda that anger and guilt and confusion and all the different ways the heart expresses its grief is perfectly normal and that the intensity of the feelings will likely fade in time. Linda seemed to find relief in that thought. What brought the most healing I believe is that Linda had the opportunity to express feelings in a safe environment she never dared otherwise. In so doing, the possibility was opened for her to do that in the future and for her to also speak up when something was bothering her. How this would impact on the other terrains of her life, such as her marriage, remained to be seen.

## **8.8 Re-Authoring the Grief Experience**

As our conversations continued, Linda went on to describe her frustration at her Gogo's stubbornness and rebelliousness that made her life difficult even as a child.

*"When her sister died, my granny was quiet, she got it in her head that I loved her sister more than her and she was a bit jealous. She was very quiet at her sister's funeral, and she sat in the corner looking angry. I wish my grandmother could just stop it, just stop it. She was so loved but she couldn't see it, she was so stubborn. Family members tried to draw her closer, but she kept herself quietly to one side."*

I ask Linda if she could imagine another emotion under the angry face and she gave me a quizzical look as she considered this, and answered:

*"I realise now my Gogo was probably trying to hide her sadness under a scowl."*

I mention that her grandmother probably struggled with so many mixed emotions and grieving the loss of a person she had a complicated relationship with is so much harder.

I wonder how this affected Linda.

*“This just killed me inside, this was my other granny. And now...I’m trying to make peace with it, to forgive her maybe. Ag of course I forgive her, but I wish she did things differently!”*

Slowly Linda started reinterpreting some of her grandmother’s behaviours through the years as the habits of a woman who was probably anxious and developed some controlled cleaning habits, and who might well have struggled with insecurity.

*“Though it seems to me so strange that she would feel insecure. She was always the more beautiful sister. But she was also the most difficult one!”*

Even though she grew up with her grandmother who was distant from her great aunt, Linda also had a close bond with her great aunt. She relates how she went to visit her great aunt often and loved listening to her stories and her laughter.

Linda read a poem at her great aunt's funeral that she had written for her.

*“My granny stared at me as I read it with deep dark eyes, and I was crying. Maybe at this point my granny realised that this was really her sister who made us all laugh.”*

As we delve deeper into the complex character of her grandmother, Linda understood that her grandmother probably struggled with her own emotions and lack of social skills, and this helped foster a sense of compassion for her. Linda’s disappointment started to dissipate and she accepted and forgave her grandmother's seeming cantankerousness.

Narrative Therapy “uses therapeutic questioning to help clients recognize and reflect on the discrepant but positive elements of their current problemsaturated stories and to empower them to reformulate a more-preferred life direction.” (Shapiro & Ross, 2002, p.

96). "Questions are used to invite people to see their stories from different perspectives and to understand how they are influenced by sociocultural factors. Other questions ask patients to envision different, more-hopeful outcomes for themselves, to probe the significance of rare but hopeful events in their lives, and help them recognize that they are constantly making choices for or against a particular problem-saturated story." (p. 97)

As our conversations progressed, new stories came, and with that, the potential for a changed, ongoing and perhaps more realistic relationship with her grandmother:

Linda suspected her grandmother changed in the half year before she died:

*"My Gogo started collecting clothes for the poor, getting involved with church more, but no one knew about it. She collected blankets and shoes and extra tins of food. She didn't tell anyone she did these things. Sometimes she asked if I had extra shoes or an extra blanket and so she got me involved too with donating to the needy. My Gogo still didn't speak to her sister though..."*

Linda wondered if she tried to assuage her guilty feelings by doing good and giving to the poor.

*"I think she was running away from that. She tried so hard to be good but she didn't want to face that, her relationship with her sister."*

Her compassion grew as Linda noted:

*"You know, I imagine when she was growing up these qualities (stubbornness and tenacity) were not appreciated in a girl... as we talk, I'm starting to feel a bit sorry for her too, not just angry."*

Linda recognised that it seemed her grandmother did a lot of soul searching that week before her passing and that it was just too overwhelming for her. Linda imagined she



must have struggled with guilt. As the stories flowed, she softened towards her grandmother, feeling compassion with a woman who was probably misunderstood in her lifetime of 83 years. After having held her grandmother in almost impossibly high esteem almost all her life, in our therapeutic conversations Linda moved to a feeling of deep disappointment with her grandmother's human failings. Eventually that gave way to a realistic and mature understanding of her granny's character, and to forgiveness of what she was, and what she wasn't; what she did, and what she neglected to do.

Linda smiled as she recalled how much she and her grandmother talked, sitting by the kitchen table. Linda loved making her tea, she knew how to make it just right for her. She remembers taking her out of the house, and even though her grandmother was restrained in expressing it, she was always grateful. She remembers how her grandmother prayed, she called every person by name and prayed for a long time. Linda believed her grandmother had *"this dam of love"* stymied by stubbornness; she could not express it, only to God and to Linda. I reflect it seems that she seems to have always meant well, she just didn't know how to make peace.

*"Maybe she wanted to, but couldn't; now I understand she was so scared when she was sitting in that corner at her sister's funeral."*

She remembers her granny told Linda she loved her after her great aunt's funeral, and cried at the memory. She added:

*"She appreciated everything I did for her, no matter if it was big or small. She was always grateful. And you know, she was at peace with what she had."*

I point out that Linda was an important influence in her grandmother's life, not just the other way around. Linda understood and loved her, softened her interactions, guided her about social interactions and built some bridges. As we talk Linda remembers often telling her *"it's alright, don't stress."* Linda mentions that her grandmother didn't feel

safe to be herself with anyone else. This was the gift they gave each other - acceptance and unconditional love for each other. Linda's grandmother encouraged her to study and be strong. Her grandmother was so proud of her accomplishments and how she helped people. She loved listening to stories of Linda's work. Together both women supported each other and helped each other to be better people. Both their identities were shaped and bettered because of their love for each other. She tells me the name of her grandmother, and we agree that *"it's the name of a strong woman."*

Another memory surfaced as we talk: Linda remembered how her grandmother blocked her aunt from taking her in as a child when her mom couldn't take care of her. At the time, Linda was angry and disappointed, but now she understood how beneficial it was to be raised by her Gogo:

*"Now I understand it better. No I understand her better."*

This was an important moment in our therapeutic conversations, where Linda's feelings started moving from grief, disappointment, sadness and anger, to re-membering, gratitude and celebrating the life of a woman who profoundly shaped the person she had become.

Linda mentioned that she had been having so many dreams of her grandmother. In one her Gogo said to Linda that she must always keep praying. In the last dream she was smiling whilst holding her hand. It was a great comfort to Linda who was worried that her grandmother was angry at her. She felt it was a sign, and it soothed her pain.

Linda told me she now understood that her grandmother was just human. She could be stubborn and resisted making peace with her siblings, but she was also a remarkable woman who raised her with good values and helped her see that as a woman she can accomplish anything. For the first time since her emotions welled up with confusion and anger, Linda felt she could forgive her grandmother for her faults and accept her in her

full humanity. Not as a saint as she did before, but as a woman she loved and continued to love. A woman who shaped her like no other human being had up to this point in her life.

*"My granny prayed for me, she blessed me, she loved me."* She said simply.

## **8.9 Searching for an Alternative Story - Identity Growth as New Ideas Develop**

Linda was starting to form a new relationship with her grandmother. As her identity changed from being a daughter and a granddaughter, Linda could also change how she viewed the women she loved who had passed away. In particular, the relationship with her grandmother who was always idealised and who was her primary parent necessarily had to change as Linda gained insight into her grandmother's complex character. Now it could move to a relationship between equals, women who felt misunderstood at times, women with failings and talents and beauty and characteristics that might not be so beautiful. As the anger slowly faded to acceptance, Linda could love her grandmother much more honestly and with the insight of an adult woman with life experience behind her.

In the story of her grandmother's stubbornness, another opportunity for identity growth came:

*"When her sister died, I asked my Gogo to please go to the family, but even then, she resisted."*

I remark that Linda is a real peacemaker. She cries:

*"This is one place in my life I failed..."*

Do you think there was anything more that you could have done? I asked.

*"No, I don't think so. Even if I could have gotten the queen of England to come and talk to her I think she wouldn't have gone."*

Guilt is a very common emotion in bereavement, but one that can keep a person stuck in constant self-berating and hinder acceptance. It was important for Linda to forgive herself for any actions or inactions she took or didn't take, in order to heal and grow. It came in a simple sentence at the end of a paragraph in one of the many letters she wrote to her grandmother:

*"The family is apart, there is lots of anger and resentment with the three daughters (her aunts). Since your passing I'm treated like a stranger in my own home. They've shared your belongings among themselves. The house is cold and dark. No words can describe what is happening, what a mess. I've spent lots of hours thinking and crying. But then I realised, it had nothing to do with me. I gave what I could, I loved, I cared and did the best I could."*

I referred back to her tears of frustration earlier that she didn't do more to bring reconciliation, and pointed out that the sibling rivalry between the aunts preceded her by many years. Linda nodded, looked down and said:

*"hmm, that's something I never considered."*

In retelling the narratives that made up the history of this family, new insights arose and problem-saturated stories could be reshaped, re-interpreted and problems established outside of herself by realising the many other influences she had no control over and for which she did not need to take ownership. Parry A, Doan (1994) discuss how problem-saturated stories that people tell themselves, and believe about who they are and what their lives signify, can become 'disabling' in the sense that the story tellers feel they have lost control of their stories and are unable to change their meaning. It may not be the story the teller wants to tell but it is perceived as the only story available, until new insights are gained. (Dewey and Winslade in Monk, Winslade, Crocket and Epston, 1997)

I asked Linda: 'Where did the idea that you have to be the care-taker come from?', 'What expectations do you think you picked on?' and 'How did this shape you, for better or worse?'.

"Narrative questioning has the intent of uncovering meaning and generating experience rather than creating information ... self-discovery and understanding are central, and the physician's role is facilitator and ally." (Shapiro & Ross, 2002, p. 97). As Linda's ally, and with sensitivity and collaboration, it was hoped that we would be able to come up with more preferred or desirable stories, especially more empowering and hopeful stories that she could tell herself.

As we reflected together and pondered how this shaped her, Linda and I were in an alliance, the 'problem' was not seated in her and I was trying to 'extract' it, her and I both examined the effects together, and she decided what she'd like to keep in future, and what she could let go of. This is not just an unburdening of the heavy weight of problem-saturated stories, it is also very empowering, and for Linda, even potentially energising. Shapiro & Ross (2002, p. 99) also note the empowering effect: 'it encourages the patient to find his/her own voice and to make choices about how he/she wants to live.'

By searching for an alternative story, Narrative Therapy theory holds, identity shifts can happen as the client's relationship to the issue changed. For Linda, the concept of guilt because she felt she didn't do enough, a very common theme for the bereaved, could shift to an understanding that there were many family dynamics at play here that preceded her and had nothing to do with her. Furthermore, Linda could move to an understanding of herself as not only as a caretaker, a dominant role in her life, but also as part of a clan of women, fallible but remarkable. And this understanding gave her permission to be human too, also fallible but remarkable. She didn't have to be perfect, she didn't have to have saved the family from all the undercurrent feuds, she could just be herself and a woman who loved all of the older ladies, warts and all.

To find alternative stories, I asked, 'are there people you know who have a different view of you?'

*"My friend Monica knows a very different side to my character. We can laugh! She always says 'come on girlfriend, we need to go shopping!'. Monica always reminds me to spend a bit of money on myself, to buy myself some pretty, feminine clothes."*

I ask 'will Monica be surprised by the stories you've told me about your family?' and 'How is that in line with what you want from your life?'

*"Well, Monica knows me. I don't have to say much for her to know. But if you ask me like that, if how she sees me is in line with what I want from my life, I think I have to answer 'yes'. You know? A bit lighter, we are a bit more playful with each other, serious, but life is always serious, isn't it? But she reminds me to laugh. It's good for me."*

Her friend encourages Linda to "let her hair down", to be playful and celebrate her femininity in beautiful clothes, to express her feelings and laugh and not to always be over-responsible. It was a good counterbalance to the serious outlook that Linda had developed growing up with role models who were two generations older than herself.

Using an 'audience' and identifying 'supportive witnesses' to the new or developing story is a therapeutic tool developed by White and Epston, beautifully described in their book *Narrative Means to Therapeutic Ends* (1990). "One of the most effective ways of strengthening the new, developing story is by creating a receptive audience who serve as 'witnesses'." (Shapiro & Ross, 2002, p. 99)

It's not easy to overcome old patterns and we were fortunate to have an opportunity to reinforce and clarify ideas. In one of our final sessions, Linda said:

*"I want to be a healer in my family."*

These are powerful words and in alignment with the identity she adopts in her world in general and in her work. But I wonder if this has perhaps become too heavy a burden for her to shoulder on her own. Though her words at the time certainly sounded reflective of an admirable ideal, Linda found the pressure of healing deep fissures between sisters in the two generations above her too much for her. Undercurrents of animosity in her family ran deep and long and we discussed whether it is indeed feasible to try to change the course of the river, a symbol for the family stream of relations.

*"It's true, I used to just work and work, just focus on other people. I always always try to help."*

In her life, Linda often found herself wanting to play the healer of the team, the peacemaker, who got along with both sides.

*"A role I so easily slip into, it's easy for me."*

But at the same time:

*"I'm getting so tired of this role, people so often don't seem to want peace. The last while I feel like I've been running on empty."*

Linda had always loved being a friend in need and a shoulder to lean on. She remembers with soft eyes a letter written by an old patient who commented on her welcoming smile and says she always tried to bring real caring to her profession. That is something she doesn't want to change. But working for peace in groups, especially in families, had become exhausting. I wondered if she can distinguish when this role will bring true comfort and healing, and when her efforts would be futile?

*"Perhaps I can be a different kind of healer, someone who just doesn't get involved in all the politics, somebody who smiles and can be a friend to everyone."*

*I really don't think I can keep trying to talk to them about their issues, they should sort that out themselves!"*

We discuss setting an example rather than trying to insist that people get along. Linda smiles:

*"That's exactly what my friend always says – lighten up girl!"*

### **8.10            Saying 'Hello' Again**

Narrative Therapy theory holds that, instead of the traditional 'moving on' and 'getting over' metaphor underlying so many grief theories in the Western world, the relationship with a deceased person can be re-established and reinforced in the therapeutic context, thereby paradoxically assisting an individual to resolve their grief. Of course, life is never the same and we miss the physical presence of our loved ones after their passing, but by allowing a grieving person full access to memories, indeed to the ongoing influence in the shape of their loved one's character, the legacy of someone like a grandmother can continue to exert a positive influence in the lives of those left behind. This can provide an enduring source of strength, comfort and inspiration in the future and I believe is a more natural way as we continue to hold our loved ones near.

It is quite natural for people to have 'conversations in their head' with the person who has passed over. To ask themselves what their loved one would have thought of their actions and sometimes be guided by their preferences. One of the ways to make these conversations conscious in a concrete way is through the writing of letters to the person who passed over.

When I asked Linda if she would like to write a letter to her Gogo, she laughed and said that in fact she had written letters and cards to her Gogo all through her life, especially as a child. For her, writing letters in therapy was the most natural thing in the world.



Towards the end of therapy, a few letters were written, some long, some just a note. Linda told me she wrote the first page of the first letter and became too overwhelmed. It was only after a few days that she could complete the five-page letter. She read it to me, and below is an excerpt:

*Dear Gogo,*

*It has been long since I talked to you, I really miss you. There are times when I think of calling you, only to realise you are not there anymore. I really miss your voice and your smile. It feels better now to know that you are okay. The times we shared, the laughter, the arguments, shopping, exchanging clothes, those are memories I will cherish all my life. Your baking, oh my it was to die for. The Sunday chicken, the cinnamon pumpkin, the pineapple pudding... ah... You loved me unconditionally with faults and all, I'm still your baby and I'm eternally grateful for that.*

*I believe and I know that I have helped you to live a comfortable life. You were always grateful for everything, no matter if it was big or small.*

*I don't regret going through all this but I'm still learning the lessons this experience has brought me.*

*Today I know you are at peace, the thought warms my heart. All my dreams about you are happy and great. I thank God that our paths crossed. Love you lots.*

## **8.11 Resolution**

It took many months for Linda to start feeling that her energy and emotional equilibrium were slowly returning again. When we said our goodbyes, she was still suffering from some fatigue though she noted that she accepted it now and realised that it will take time, she had suffered such a big loss. She was grateful for deeper understanding and had made her peace with the complicated relationships in her family, accepting that it wasn't her burden to repair them. Linda felt she understood the characters better as

well as her place in the new family structure, and although she dearly would have wished for more closeness, she found joy and togetherness in her friendships and some hobbies she had started to take up.

During our last conversation we discussed the way forward. Linda was unsure what would become of her marriage, but for now she just needed to fully heal from her losses. She had an ongoing relationship with her three mother figures and her grandmother continued to play an important role in her thoughts and decisions.

It is natural for a therapist to want our clients to 'feel better', and to a large degree Linda did, but to some degree she was still busy with the journey of her grief when we decided together that our conversations had run its course. We remain in occasional email contact which is always, like her character, warm and sincere.

*The reality is that you will grieve forever. You will not 'get over' the loss of a loved one; you will learn to live with it. You will heal and you will rebuild yourself around the loss you have suffered. You will be whole again, but you will never be the same. Nor should you be the same, nor would you want to.*

~ Elizabeth Kubler-Ross and John Kessler (p. 230)

## Chapter 9

### Nancy's story: Losing her Other Half

*"Grief does not change you, Hazel. It reveals you."*

~ John Green, *The Fault in our Stars* (2012, p. 286)

*"Don't grieve. Anything you lose comes round in another form."*

~ The Essential Rumi (1995, p. 272)

#### 9.1 Personal Data

Participant:	Nancy
Age:	Sixty
Field of Occupation:	Reception
Education Level:	High School Certificate
Therapeutic Setting:	Psychology private practice
Language:	English
Therapeutic Conversations:	16

\* In the final report names and some identifying particulars were changed in order to protect the identity of the participant.

#### 9.2 Introduction

Nancy came to see me 20 months after her husband passed away from bladder cancer. She was struggling with low mood, teariness and feeling overwhelmed and stressed. Although Nancy said she was *"mostly fine"*, she admitted she was struggling and finding it hard to stop crying.

*"I need to cope better, but I will never be over it..."*

### **9.3 Socially Constructed Grieving**

Nancy seemed to be stuck in a loop – the advice she was getting from those who cared about her was that it was time to accept the passing of her beloved Tom, and that she had to accept that she is alone now. Although this seems like an obvious statement of fact, it caused Nancy strange mixed feelings of guilt when she cried and yearned for him, and rebellion toward those who advised her to move on, followed by guilt that she knew they meant well. She asked me a few times –

*"How long does it take?" "How long do people grieve?" "It must be okay to still feel sad about Tom right? You know he was the love of my life, he is my soulmate, and after all, we were together for thirty years!"*

Nancy struggled to justify her natural feelings to what she viewed as society's expectations. She felt upset when people said she is still young and attractive. And she felt confused by the implied comments meaning that she should have been feeling better by now. This strengthened an old belief in her – that she wasn't good enough, or strong enough. This was an old story of perceived inadequacy that made her journey of developing a new identity much harder.

From the point of view of *Social Constructionism*, the narratives of our world we hold so dearly are in fact jointly constructed understandings based on shared assumptions of what is and what should be. Without realising it, we are all party to these narratives and societal expectations, and interpret our own behaviours accordingly. If we therefore perceive our behaviour to fall short of these societal constructed expectations, we might feel lesser than, not good enough, not quite up to scratch, because for almost all of us being accepted by our peers is important. Whether the subject is ideal beauty in the time of the Renaissance compared to today, or the way a woman should relate to her

husband, societal expectations vary in the historical or cultural framework they find themselves in. Yet, without always consciously being aware of it, we buy into the ideals of the day.

Nancy's grief experience was complicated by expectations of how she should be grieving, and for how long. These expectations of course would vary according to where she found herself in the world. I thought it would be helpful to gently remind her that grieving is not the same for all people but is in fact a highly personal experience. Moreover, if she were living in Thailand or Iran or in the Middle Ages, there would be different expectations of how to 'mourn properly'. Lorraine Hedtke notes that while death is a biological event, the ways in which we make sense of it are shaped by the social discourses of the worlds in which we live: 'This process is both produced and sanctioned to not take too long, not be too messy, not dwell on our loved one's memory, and not include public displays of extreme emotion. A focused tacit conspiracy actively dismembers the stories and meanings and intimate connections of our loved one's life. The rules are: say goodbye, move on and resume life as soon as possible.' (Hedtke, 2002. p. 4)

The customs we create around death and grief are not born in a vacuum, but are reflections of our thoughts and meanings and reflected in our language, also as therapists (White, 1995). These cultural and linguistic patterns of grieving often shape and mould the experience into what is considered normal or pathological. Even when the words of well-meaning friends and professionals may be expressions of compassion, they story expectations of how the bereaved should grieve, and if their grief trajectory is different, the bereaved is left bewildered, questioning whether they are 'normal'.

I suggested to Nancy that she ask herself what feels natural to *her*, what is appropriate to *her* unique relationship with Tom, and allow whatever she feels to be there naturally. I was hoping that in so doing, Nancy might learn that her needs and feelings are natural

and important too, and hopefully this might bring about greater self-acceptance and eventually quiet confidence in general. This I believe is where grief counselling becomes grief therapy – an opportunity for identity growth necessitated by the life crisis the person finds themselves in when they knock on the door of a Narrative Therapist.

#### **9.4 Mapping Influences**

Nancy is an attractive, slim, soft spoken woman with soft, natural, short silver hair. Her green eyes looked woeful and became teary every time she spoke about her husband who had passed away. From her body language and demeanour it was obvious that she was struggling with confidence and I wondered if it was because of her loss, or whether it was there before. Nancy acted as a host and receptionist at a food and wine business, a job she said she used to love, but *“now it just pays the bills”*.

Nancy has two daughters in their twenties, one still studying for a post graduate degree, the other in her first year of working after her studies. Nancy spoke about her daughters with obvious pride and fondness, describing them as quite different - one determined, outgoing and ambitious, the younger more sensitive and introverted.

Nancy was faced with big financial decisions that she felt incapable of handling. The family farm had become too much for her to manage and she needed to decide whether to sell it, and where to live afterwards should she do that.

#### **9.5 Thickening the Narratives**

It can be very healing to tell the full story of our loss to someone who is willing to be an ally in the journey of grief. Too often a bereaved person tries to put on a brave face to the world and avoids making others uncomfortable with their grief. This can make mourning a very lonely process compounding the burden of loneliness caused by the vacuum left by the one who passed away.

By asking Nancy to 'tell me more' she is invited to '*thicken the narratives*' with all the many nuances of their shared love story and of her grief story.

Nancy grew up in a small rural town in a close-knit community and part of a very loving family. Her household was fairly traditional, with her father being the breadwinner and her mother raising the children and keeping the home. She describes herself as a quiet child who played happily by herself, dreaming of princes and castles and faraway lands.

Nancy met Tom when she was nineteen at a country ball. He was a striking figure with his lanky body and dark hair and she was immediately smitten by his seemingly sophisticated knowledge of the world. In our first session she said:

*"I didn't expect the loss of our fairy tale."*

Nancy and Tom were inseparable from the start and were married within a year. They always got along well, Nancy told me, and their relationship was characterised by Tom being a strong and ambitious character and Nancy supporting him as best she could. His career took precedence and she was content to stay home to raise the girls, only going back to work when they reached school age. She loved being a homemaker and caretaker and says she was fulfilled by her roles as wife and mother.

*"He was our world, he was just always there. He was confident and strong and people relied on him and came to him for advice. Tom always knew what to do. He loved teaching and showed us how to do things on the farm. We were always very close. We were soulmates..."*

When their daughters started going to school, Nancy started working in order for Tom to study and he did a degree in property management. A few years later Tom approached

Nancy with his lifelong dream – to buy a small farm and start a citrus orchard under irrigation. Without hesitation, she once again supported him and they moved back to the country. Nancy loved their lives there. They became part of a close-knit community and she felt her daughters had a childhood that resembled those of their parents’.

*“We had wonderful neighbours; some were even like grandparents to our girls. What really shook me was that a few neighbours died around the same time as Tom. It felt like the bottom of my world was falling out. There’s an old lady in her eighties I’m still close to. She tells me it’s hard being old and alone. It makes me wonder about my future.”*

I encouraged her to tell me more about the love that she and Tom shared. Nancy seemed relieved to be able to talk about it freely and fully. She described how she loved that Tom always took good care of his health, eating well and exercising. He was tall with strong hands and he was usually tanned from working on the farm.

*“In the evenings after dinner, we would make tea and talk. Tom would tell me all about his day and his projects. He always seemed to be busy planning more projects! We loved spending time in each other’s company. I really miss his voice. And his laugh. He laughed easily. Sometimes he became broody and would disappear into his study for hours. It usually lasted a few days. In the beginning it bothered me, I felt like he stopped loving me. But later I realised he just needed time alone and eventually he would come out and talk to me again.*

*In the mornings, he would sit on the edge of the bed chatting to me while I was busy getting ready. He was my best friend and I cannot tell you how much I miss him. My mornings and evenings are very quiet now.”*

I wonder how she felt about the farm:

*“It was always Tom’s dream. I trusted him; he was a good business man. But it was initially difficult, we didn’t have much of an income until it was properly*



*established and that took years. So in that time we both worked in the town. Tom made business connections in the town and there was some income from work he did. I really didn't mind supporting him, and it is peaceful on the farm."*

It was obviously a testament of her great love for Tom and her willingness to support his dreams, and he must have appreciated her support a lot, I reflected. But I wondered if she had any dreams of her own that she put on the backburner while the business was established and so on?

*"I'm not a very ambitious person. But one aspect where Tom and I differed was that he preferred farm life, while I actually like living by the sea."*

It was something she could consider in this new phase of her life, I said. And in later conversations this possibility was discussed more.

## **9.6 The Loss**

Tom had been a picture of health all his life so it came as a terrible shock when he went for a check-up at his GP following unusual fatigue and urinating difficulties. Referrals to specialists, scans, surgery, hope and worry flowed into twenty-one months during which time Tom became pale, thin and tired, to the great distress of the people who loved him. Nancy went to all his appointments and supported him emotionally and practically as best as she could. As she tried to keep it together for her family her world was falling apart. Tom came home to die. Nancy describes his treating physician as a kind man and everything was done to make Tom as comfortable as possible. Tom died in a specially made up bed in an area in the family living room, where he had spent the last weeks of his life. Nancy and his daughters held his hands while his doctor provided support. After almost two years of stress and worry it was suddenly over.

*"It was terrible to see him suffer; it felt like a nightmare that just went on and on. After a while I couldn't stand it anymore. I feel guilty that in the end I just wanted*

*it over. But I think he did too. Tom was very concerned how we'd cope after he died. He tried his best to get his affairs in order. His doctor said that is one of the blessings of cancer – you have time to get your paperwork done and say goodbye. It didn't really make it easier. Well, maybe it did afterwards on a practical level. But I was still losing my Tom and there was nothing I could do about it. All my life we went to church and I still believe in God. But I don't understand why there is suffering in the world. In the end we were all very tired and it was almost a relief when he finally passed away. I felt guilty for thinking that but I know that if Tom were in my shoes he would not have wanted me to suffer either."*

Although the journey with Tom's cancer was a traumatic one, and seeing the man she adores leave life no doubt distressing, Nancy seemed to have come to terms with the passing itself. She told me the narrative of his struggle with cancer fairly calmly and when asked said she tries not to remember Tom the way he was in the end. When I met Nancy for the first time, she expressed that her greatest concern was rather about how much she missed his presence, guidance and company in her life. The fact that almost two years had passed since Tom died probably contributed to the fading of the trauma of his cancer and death, and increased awareness of him not being there as her companion.

## **9.7 Many Unexpected Losses**

### **9.7.1 The Loss of her Guide and Partner**

When Nancy and Tom married, it wasn't just a fairy tale built on romance and attraction. The two of them had built a solid friendship, provided each other with support and companionship, weathered change, the passing of their parents, financial insecurities and changes in homes and work. They raised two daughters, built up a successful business through hard work and determination, and built a marriage that stood the test of time. They had what most of us aspire to have – a lasting and beautiful loving relationship. A solid love like this provides comfort, security and a safe haven in an ever-changing world. It was little wonder that Nancy felt vulnerable and adrift.

Besides the loss of Tom as her life a partner, Nancy also lost ready access to his guidance and ability to make major decisions. When she needed help or wondered what the best course of action was, she naturally turned to Tom for guidance.

*“Now that he is gone, I always ask myself what Tom would do when faced with a decision. I don’t always get the answer, but it seems to be a rudder in the storm, something to steer by. It’s almost impossible for me to come up with a solution without thinking like this. I’ve done it so long.”*

### **9.7.2 The Loss of the Wholeness of Family**

After the death of their father, Nancy’s daughters returned to the city and seemed to get on with their lives. Although sad about their father’s passing, a young person’s world was beckoning and they joined it. Visits to Mom were different from visits to Mom and Dad:

*“There are just three at the table now, and the conversation is somehow different. After Tom died they seemed to be the strong ones, and I got the sense they felt a bit sorry for me. They tried to be cheerful of course, bless them, they are good girls. It was just different. Tom used to tease them and the conversation flowed more normally when he was here.”*

### **9.7.3 The Loss of Financial Security**

Although Nancy worked and earned a salary for many years of their married life, Tom paid the bills, did most of the online banking and organised insurance loans, contracts and so on. Nancy felt like a fish out of water in dealing with the world of finance. It was a steep learning curve for her to understand what needed to be done while she was in the midst of her sorrow.

*"I had to toughen up, make appointments and go and see financial advisors, people at the bank, lawyers and conveyancers and so on. Unfortunately not all of them were honourable, but thankfully I now have a few people whose advice I trust. Tom wanted to spare me this and he left me lists of people with their numbers. But it didn't all turn out well. In the end I think Tom would be a bit surprised that I'm managing these things. I'm certainly surprising myself!"*

#### **9.7.4 The Loss of the Identity of a Wife**

When a couple has been married for so long, friends and family start thinking of them as a unit. Often, couples and families would get together and friendships would form between all of them. When that unit is broken, it affects how people respond to the person staying behind. For Nancy it was an unexpected experience after Tom passed away:

*"When I used to sign a birthday card to the girls, it was from 'Mom and Dad', when we were invited, or sent a sms or a card, it was always from Tom and Nancy. We were a unit. I don't know who I am if I'm only Nancy. It doesn't even feel like I'm half of the whole. It feels like I'm half a shadow of what we were."*

*"The strangest thing happened too, that I didn't expect. It's like people are a bit different with me now, even old friends. They don't quite know how to be with me. Sometimes I get invited to dinner parties and it's all married couples, and me. And I know they feel sorry for me and try to include me, but I don't quite fit in the same way as we did when it was Tom and I together. I tend to leave before all the others do because it's a little bit awkward with some of our old friends."*

#### **9.7.5 The Loss of her Home**

During the time of our therapeutic conversations which spanned almost ten months, it became clear to her that she couldn't handle the farm herself. Nancy struggled with

terrible guilt and felt that she would betray Tom's memory if she were to sell the farm. In the end, the weight of responsibilities became too much, and Nancy decided in consultation with her daughters to put the farm up for sale. For months she was unsure what would happen, would it sell quickly? Or not all? And what would she do then? Was she doing the right thing by Tom?

On the farm the couple had built their dream family home. It took many years of saving and planning, but ten years after buying the farm, they finally moved into their beautiful home. Both Nancy and Tom preferred a minimalist style of decorating and the home was decorated in earthy, muted colours. Nancy loved the house and every room held memories. It was also the house that her daughters grew up in and came home to from university holidays.

## **9.8 An Emerging New Identity**

In the journey of her bereavement, Nancy was required to steel herself and do things she was shielded from doing while Tom was alive. She had to decide what to do about the future of the farm, and how to manage the myriad financial decisions that she suddenly found on her path. Her decisions would not just influence her own future, but those of her daughters and the farmhands who worked for them. It was an ideal time for Nancy to step up to the task and in so doing develop dormant parts of her character. Doing so required courage in a time when she was definitely not feeling emotionally at her strongest. But if Nancy succeeded, nothing would ever feel quite as daunting again.

From the way she cared about her daughters and her husband, supporting them in their dreams and aspirations, even sacrificing her own in the process, I reflected to Nancy that she strikes me as a very giving, nurturing person. I asked Nancy whether these were characteristics she developed as a mother and wife, or whether she was like this before.

*"I grew up in a big family, and I was the youngest. We weren't very well off and most of my clothes were hand-me-downs. I was always very aware of my mother who worked hard to keep home and hearth, and made sure we were all fed and warm. I reckon she was my role model. I didn't want to make things harder for her, so I tried not be too demanding. Besides, I always thought my older brother and my sister Linda were much cleverer than I was."*

I reflected to Nancy that characteristics such as consideration of family members and kindness are certainly wonderful traits, and must have been born from love. Then without prompting, there was a little breakthrough in our therapeutic journey, as Nancy said with a far-away look in her eyes:

*"Yes, there was a lot of love there. But you know, I don't know if my mother was really happy. I know sometimes I found her sitting by the dining table in the dark, after we've all gone to bed, crying softly. Looking back I think, for my mother it was always about us, and now that I'm older I can see that she probably never really developed her own voice, asked for what she needed too."*

It was a moment where the potential for self-insight and identity growth presented itself beautifully. I asked Nancy if there were similarities between her mother's choices, and her own, and whether there is anything she can learn from it and apply in her own life. She thought about it for a long time before she answered:

*"I wish my mom spoke up a bit more. I think she had some good ideas and many talents, but she let my dad make all the decisions. Some of his decisions were good, but I know that some of them were not the wisest. If my mother had spoken up, our lives might have turned out differently. I remember even as a child thinking it was unfair. And you know, well, you know I have a very high regard for Tom, and I think he was a very intelligent competent man. And you know, I wouldn't have our lives together any other way. But... Maybe I should have sometimes given my opinion instead of always saying to him 'you decide Tom, I*

*know you'll know what's best.' I don't know if it would have made any real difference in our lives, but now I wonder if leaving all the decisions to him made it hard for him."*

It seemed to me that she was now tasked with having to make many decisions, and I imagine that that must feel overwhelming to her, I said.

*"Oh yes! I lie awake at night wondering what to do, I beg Tom to tell me what to do! But of course, he's silent."*

This must require a lot of courage, I reflected to Nancy: to do something that you're not used to, and knowing that the consequences of the big decisions are your responsibility.

*"That's the thing I think people don't realise – how scared I am of making the wrong decisions."*

It was an opportunity to gently address the subject of self-confidence: sometimes we don't feel we are capable of doing something, or we are not sure, and then we avoid doing things, I said. And in avoiding things, like contributing to big decisions, we actually never learn if we can, and end up believing that we probably can't, even though that has never been tested.

*"Well I don't have a choice now; it is up to me and only me now. Last Tuesday I had to go and see a lawyer about some water rights issues to do with the farm. There is a neighbour who is contesting the water rights on the farm, now that he heard I'm planning to sell. All the years we were good neighbours and got along well, so I was quite surprised when there was suddenly an issue. Ah well. I had to prepare before the meeting with the lawyer, get all the paperwork together like Tom used to do, ask people who the best person would be to see about this, and I went! And it wasn't so bad, I managed. I surprised myself actually."*

These are the shining star moments that Gerald Monk (1997) refers to in *Narrative Therapy in Practice: The Archaeology of Hope* – those moments in therapy when glimpses emergence of characteristics or behaviour that can transcend the problem-saturated story. It is the task of the Narrative Therapist to point these moments out, emphasise their significance, and thereby release the hold of the stories a client tells him or herself about who he or she is or isn't.

A discussion followed about the characteristics she's developing in this process like self-assertiveness, clarity in communication and fighting for what is rightfully hers. Nancy was slowly but surely unearthing strengths she never knew she had, and in so doing, gradually growing in confidence after a lifetime of being modest and submissive. We laughed together at the unexpected growth that took place in this time, when her only aim when she called to book her first appointment was to feel better.

Shapiro & Ross (2002) emphasise the significance of '*creating an audience*' for the new growth that is taking place, so that the tender first growth that appears in the therapy room, can be carried out and gain momentum in the day to day world of the client. These friends can bear witnesses and provide support and encouragement for the new patterns of behaviour. To this end, I asked Nancy who in her world would be happiest about her growth?

*"Oh, for sure Karen, my eldest. She's a bit of a fireball that one! She has told me many many times 'come on Mom, you can do this, it's easy peasy!' She would be so proud of me for going to lawyers and making all these decisions. She doesn't seem to have a scared bone in her body!"*

Nancy and I discussed how to approach this in such a way that Nancy won't lose her voice again in interaction with yet another strong character, whilst maintaining her growth. Nancy realised that it will require of her to also be assertive with Karen in as



nice a way as possible. She left what would be our third last conversation with seemingly a little more confidence and a square set to her shoulders that I hadn't noticed before.

## 9.9 Re-Authoring the Grief Experience

Nancy refused to take her wedding ring off, and wore Tom's on a chain around her neck. She did not want to think of herself as single again, and was relieved when I said that I understood, and that it was up to her how she wanted to relate to Tom from now on. She told me that almost every well-meaning friend, even her doctor, told her it's time to move on, and get over it. She didn't want to! And who are we to say a marriage is over when a spouse dies? When one loses a sister, do you stop being a sister? When you lose a child, do you stop being a parent? I told Nancy my thoughts about this - that the identity she assumes and shapes from now on, is up to her. Nancy was very relieved by this as she expected her psychologist to be just another person encouraging her to 'get over Tom'.

*But what does this mean practically?* she mused. We explored this together.

*"I am a one-man woman. I definitely don't want to get involved with another man again; I just can't see it happening. Tom was, is, the love of my life, and that will never change. I don't want to be invited to dinner parties where it is obvious that my friends are trying to set me up with someone. I don't want to date again. I'm not young enough. Or even if I were, I'm just not that way inclined. He was my one and only."*

Nancy and I discussed how she might make this clear to her well-meaning friends without them taking offense. It required courage from this otherwise soft-spoken woman and thus presented yet another opportunity for her to flex the muscle of self-assertiveness that she had started to develop.

From a social constructivist approach, reality is viewed as being constructed by the people in the community. This implies that how and when and even how long one is 'meant' to grieve are constructed by the society one finds oneself in. Even our grief theories and therapies, rather than being reflective of any ultimate reality, are reflections of certain socially agreed upon definitions and conceptions of reality. Yet they "exert a powerful effect on our emotional and behavioral experience and reactions to events and situations" (Nell, p. 117). Most models of grief counselling or therapy viewed counselling as successful when the person is able to move on and resume life without the loved one. It was clear that Nancy was measuring her own grief against an underlying societal belief of how things should be done:

*"But I wonder, is it healthy to want to stay married to him? Will people think it's strange?"*

I asked Nancy whether staying married to Tom feels natural to her.

*"Yes! It's the most natural thing in the world! I want to stay true to him; I want to continue loving him. I want to keep talking to him, even if it's only in my head. I still feel like he shares my life. I don't know how, I don't know if it's just my imagination, but I feel Tom's presence all around me and I find that very comforting. And then I just get on with the day and do what I have to do. It actually makes it easier for me than if I had to go through a death and a divorce!"*

To my mind, the question about healing from a loss is about the person's ability to engage again in life, to work and socialise and take care of themselves, their finances and the many chores of a human life. As a therapist, I look to how the person is feeling, if there is enough emotional equilibrium to engage in life, appropriate sadness at loss, and the capacity for and openness to other emotions like joy, even if it is not to the same degree as before the loss.

I resonate with Narrative Therapy's view that a person does not have to 'get over the loss and move on' to be 'healed'. When a person very close to us dies, life is never the same

again. We are never the same again. And would we want to be? Whether Nancy fell in love again with another man or not, would not be a definitive sign of her healing from her loss, in my book. And if for her, staying emotionally married to the love of her life, who are we to say that is wrong or unhealthy?

To confirm that Nancy has indeed re-developed the capacity for the full gamut of human emotions, I ask Nancy if she had moments in the past week that made her smile. She gives a little giggle as she tells me about her dog:

*“I know it’s silly, but every morning when I wake up, Charlie runs around the house like a mad thing, so happy I’m awake, chasing who knows what and skidding on the wooden floor. And it just makes me laugh, the silly thing!”*

It was clear that Nancy was no longer only able to access feelings of sadness and despair but was starting to find more balance in her emotions, whilst incorporating her husband of thirty years in her present and her future in a new way.

## **9.10            Saying ‘Hello’ Again**

In 1988, Michael White, one of the founders of Narrative Therapy, wrote an article called ‘Saying Hello Again’. Nell (2009, p. 118) explains: “the *saying goodbye* discourse gives rise to the idea that the client has to learn to ‘let go,’ to work through his grief and to ‘put it behind him.’ Rituals and other practices are often used to ‘help’ the person accept the finality of death by *saying goodbye* to the loved one who passed away. These ideas are implicit in many approaches to grief counselling.” “The death-as-final discourse precludes the possibility of seeing or using such an inability to ‘say goodbye’ in a positive, more constructive way. In therapy, the result is often a battle, where the person has to fight his lingering feelings of attachment to the deceased loved one in an attempt to ‘let go’.”

Particularly relevant to Nancy and the socially constructed assumption that it is time for her to get over the loss after more than a year and a half, Nell further notes that “therapeutic endeavors designed to aid clients who are struggling with protracted grief and mourning over the loss of a loved one might be enhanced by the incorporation of the *saying hallo* metaphor.” (p. 117)

Since Nancy very much wanted to keep Tom in her heart and remain ‘married to him’, I explored the concept of ‘saying hello again’ with her: I asked Nancy to tell me as much as she’d like about Tom, what he enjoyed, what made him laugh, how he loved her. It was bitter sweet for her to tell me and naturally quite emotional. But it also provided Nancy with the opportunity to tell me about the man she still loved without needing to censor herself or hold back. There were no grief police in the room.

I asked Nancy: ‘How could you honour Tom’s memory and influence in your life?’

*“No one has ever asked me that before.... What a strange thing... I have a beautiful framed picture of him next to my bed, he smiles in the way he used to when he was happy. It makes me miss him so much! But it also reminds me of how he looked, I never want to forget. And... I haven’t told anyone this, but at night I say goodnight to him, and in the mornings, I say good morning.*

*But you asked me about honouring his influence, didn’t you? I think the most important way is with our girls, we talk about Tom often. On his birthday, we had a picnic on the farm for him. Did I tell you we planted trees for him? 63 trees, he was only 63 when he died, and he loved trees. So, we packed a basket of all the food we used to enjoy on picnics with him, and walked to the trees with our dog, and just remembered times we spent with him.”*

Nell (2009) discusses ways that bereaved persons may use to ‘say hello again’ and in so doing keep the memory of their loved one alive in his beautiful article *The saying hallo*

*metaphor as alternative approach to death-related counselling.* Nancy quite naturally enacted some of these rituals herself, such as keeping a favourite photograph of Tom next to her bed and saying good morning and goodnight to the image of the man she has loved all her adult life.

Nell also describes the therapeutic value of dreams about the person who died. When Nancy told me in an offhand way that she occasionally has dreams of Tom, I asked her to tell me more. I wanted her to know that I value her unique grief experience and that her experiences are never unimportant:

*“They feel very real. He doesn’t say anything, I just feel his love and I believe he really does still love me. The next morning after one of those dreams, I’m usually a bit teary, I just miss him so much! But I wouldn’t give up these dreams for all the money in the world because for a little while he feels alive and with me.”*

In our fourth conversation, I invited Nancy to write a letter to Tom if she felt ready to. I explained that it may help her to get words on paper that expressed her feelings and thoughts. This could especially be helpful since Nancy was used to having daily chats with Tom and often said how much she missed their talks. The next week she told me she wrote a four-page letter to Tom, thanking him for his love through their lives, for their children, for accepting her the way she was, and for always taking good care of her.

Nancy was surprised when I suggested that the next letter she wrote be from Tom to her. Nell (2009, p. 120) notes that “These letters are intended to instigate a position of reflexivity in the client from where he can perceive his own situation from a new perspective (in this case, that of the deceased), a process which is often generative of therapeutic change. Through writing such a letter, the client is extricated from his own vantage point.”

Nancy found this letter much more difficult and it was only a few weeks later when she said that she managed to finish this second letter.

*"I don't know why I found it so difficult... it's not that I don't know what he would say, I know Tom very well. It's more, well, I know he would be proud of me, and I didn't want to sound as if I was blowing my own horn. But then I sat where we always used to sit at night, and I lit some candles and had a glass of wine, and I could hear his deep voice as I wrote. My tears dripped all over the page but somehow I felt like the words were more from Tom than from my own mind. That night I slept really well and I've been sleeping better ever since."*

"... the loss of a loved one need not be final and total. Although there is indeed such a loss as far as the physical presence of the deceased is concerned, on other levels the influence, memories and legacy of the deceased will continue to exert an influence in the life of those left behind. Such memories or words of wisdom can continue to be a source of strength, comfort and inspiration in the future." (Nell, 2009, p. 119)

### **9.11 Re-membering Tom**

If we believe that grief and bereavement practices are socially constructed, then surely the bereavement practices that are unique to each family could be consciously crafted to maintain the bond with the father and husband in a way that is beneficial to its members. One of the first professionals to plead for a more compassionate view when dealing with those who are dying and those who are bereaved, Elizabeth Kübler-Ross, in 1991 wrote in *On life after death*, "If families can cry and talk together about the happy memories they share of the missed person, the real process of bereavement can be greatly enhanced . . . If relatives can go through the pages of a photograph book and share memories of places, vacations, incidents, and laugh and cry together, much can be done to . . . get through the mourning process without scars." (p. 74)

Towards the end of our therapeutic conversations when I knew Nancy was going to see her daughters for dinner that coming weekend, I suggested she asked both of them: 'What are the most important things you have learned from Dad?' Nancy tells me a fruitful discussion ensued and the family bonded as a new unit. This time she said that, in contrast to previous slightly awkward get-togethers, the conversation flowed naturally with more laughter and tears and natural expression. She never told me what was discussed, and I didn't ask. I felt that they must have been memories too precious and personal to tell someone from outside their close circle, and I respected that.

Nancy did say:

*"When our youngest said 'I wonder if Dad knows what is happening in our lives, what he would say about all the things that we did since he died', I tell them I think he sees everything and he is proud."*

## **9.12 Identity Growth**

As the weeks became months of therapeutic conversations, it was clear that Nancy was gradually becoming surer of herself. Her grief experience brought the unexpected gift of affording her the opportunity to overcome old insecurities and lack of assertiveness that were hallmark characteristics all her life, that didn't serve her well. Nancy made the difficult decision to sell the farm, which she did. She negotiated water rights with a challenging neighbour in a calm and determined manner, striking a deal that seemed fair to both parties. Nancy's relationship with her daughters changed subtly as well – after Tom died, Nancy felt that she was to a degree pitied by her daughters, reinforcing old feelings of feelings small and lesser than. With time, the three women found a different rhythm, one of mutual respect, consideration and humour. Nancy was aware that as a role model to her grownup daughters, she wanted to portray a model of strength to them, and this kept her going particularly when she had difficult negotiations about water rights.

Two and a half years after Tom's passing Nancy completed a short course in medical reception work and found a job at a medical practice by the coast, where she always dreamt of living. When I last heard from her she said she loves taking long walks by the sea with her dog and that she feels at peace.

In our final conversation together, Nancy and I discussed how the experience of losing Tom changed her:

*"I am much more serious, life isn't simple anymore. Maybe in a sense I grew up. I had to. I do not trust everybody that tells me they'll do what they promised. I am much more wary and not so naïve about people's intentions. That's a bit of a pity, but I think it was also important for me to learn. I've learned to talk to lawyers and negotiate deals and stand up to bullies like that neighbour who contested the farm's water rights.*

*I think I'm a better role model to my girls now. They can see that a woman does not have to stand back for a man, and I think that's a good thing. I think the girls see me as a woman who cooks and cries and dreams, but that I can also be tough. They never saw that part of me. It's a better balance.*

*I'm finding that instead of leaning on others so much, sometimes people lean on me. Not just the girls, one of my friends in particular too. She told me I'm strong. I never thought of myself as strong.*

*I'm still lonely, and I miss him every day. And I think I will for the rest of my life. The sadness never really goes away. But I don't want to die anymore. I have some hope for the future, I'm making plans and I think I'll be okay. In my future Tom will always be there. I mean, even though he's not physically with me, I still talk to him. In my heart I am still married to him and I think I will die that way. Now I know that that's okay. Our love really did transcend death and I'm in awe of that. It seems to me that so many things don't last in the world. I'm a little bit proud of the fact that our love did last and is still there. It's the most precious thing in my life."*



## Chapter 10

### Narrative Analysis & Emergence of Common Themes

*Per Ardua ad Astra – Through the struggle to the stars*

Royal Airforce motto

#### 10.1 Introduction

Grief, as much as it is a universal human experience, is a highly personal experience for the bereaved person. The bereaved person not only has his or her unique character and background, but the experience of the relationship with the deceased person is unique to that particular grieving person, and consequently, so too, the loss. Human beings have highly nuanced interactions with others and, though there are certainly broad commonalities, each loss is unique and different.

I have chosen people who were in need of therapy after their loss, not all people need it: those suffering from grief 'that make necessary a reconstruction of beliefs, meanings, and the life narrative.' Calhoun et al. (2010, p. 136). Bonanno and Lilienfeld (2008), Larson and Hoyt (2009) as well as Calhoun et al. (2010) note that clinical interventions for grieving persons is not always useful or needed, but is often helpful for those who struggle. Therefore, it is important to distinguish whether a person is getting stuck in debilitating sadness or perhaps find themselves in a life crisis after the death of a loved one, from a person who is likely to bounce back to life efficacy and emotional equilibrium in a reasonable time frame without professional intervention. The authors note that for those who do seek professional help, the outcomes are often robust and comparable to other forms of psychotherapy.

The people I describe in this study are all bereaved persons greatly challenged by their loss. Their high levels of distress tipped their world upside down, so to speak, and led to a deep degree of soul searching and the possibility to reconstruct new beliefs about their

world. Their loss changed their life narrative on a very deep level: it challenged their views about themselves, their strengths and weaknesses, their assumptions about others, their core beliefs and often it challenged or strengthened their existing beliefs about the metaphysical. It also provided fertile soil for new meaning making and growth.

As far possible, the aim in this study was to give voice to the unique experience by each of the bereaved persons, whilst noting the commonalities and themes that emerged:

Mia lost her son and husband at the hand of her husband in an act of vengeance. Mia went from wife and mother to a widow without a son to care for. She was in shock not only because of the murder of her son by the hand of his father, but also what followed thereafter.

Cara's father died from cancer, leaving her an adult-orphan who had to re-invent her place in the family and in her world.

Linda lost three mother figures in the space of a year – her mother, grandmother and great aunt. Like Cara her position in the family changed dramatically causing her to reconsider her relationships and the roles she played.

John's son and only child committed suicide leaving him bewildered as to the reasoning behind his son's decision. John in particular found meaning and healing through giving back to the community.

Nancy's husband was her rock and guiding light. When he died, Nancy felt unable to make the big decisions she was faced with and cope with the many things her late husband had handled in their lives. She too uncovered hidden strengths in herself and surprised herself with what she was capable of.

## **10.2 Narrative Therapy as a Bereavement Model**

Narrative Therapy was chosen as therapeutic model for a variety of reasons. It seems that memories and stories naturally surface after a loved one dies. As these narratives are remembered, it may bring comfort and bitter-sweet joy, but often it brings sorrow, a

deep sense of loss of what could no longer be, and sometimes it brings bewilderment, especially when a relationship with the deceased was complex.

A psychologist or grief counsellor who acts with *narrative empathy*, compassion and respect can allow the *problem saturated stories* to be explored and made sense of. A process of *deconstructing* takes place - aiming to understand in depth and breadth the whole experience and giving space for the bereaved person to express all of their experiences without judgement and the need to censor themselves. The relationship with the person who has died is explored in detail, even the unflattering memories and disappointments, without flinching and with great compassion by the one who listens to the narratives. '*Thicker*' narratives are created by exploring the richness and multi-dimensionality of the relationship and how this has impacted on and shaped the bereaved person through a process called '*mapping influences*'. Sometimes *alternative stories* emerge as new memories surface or *shining moments* are celebrated when the bereaved person acted with courage or the like.

Focusing on *what remains*, rather than only what is lost when a person dies, has a therapeutic effect because it re-establishes a natural connection to those who have passed. When someone dies, it is common for people to remark 'I know you loved him or her'. But love doesn't end with the last breath, nor does hate or anger or for that matter conversations with the person, even if they take place in non-verbal form. All of the persons in this study were encouraged to write letters to their loved one that died. There was no mention of harshly cutting ties or expectations of moving on. Rather, naturalness in being with whatever emotions arose was encouraged. If there was longing, or love, or anger, they were compassionately explored as valid for now. And when love was expressed as enduring, as Nancy did for her husband, or Mia for her son, or John for his, it was accepted as natural and precious. The relationship went on as much as the bereaved felt it natural to do so. This concept in itself brought great relief, also from the struggle with a perception that a bereaved person should 'move on'. Interestingly, with freedom to love and relate to their loved ones in ways that are

natural, the relationships normalised and it seemed to become easier to engage in the present and tentatively explore a future where the bereaved remained a continued part of their lives.

The task of the helper then is not to sever the connection and establish a person who has managed to individuate without the person who died. Rather, the aim is to remember and re-member the person as part of the bereaved person's community and family, and acknowledging the connection with all its facets. That means being willing to let the person speak of their love, as well as exploring the more complicated aspects of their relationship. In Mia's case it ironically allowed her to not only make sense of the many distressing aspects of her life with her late husband, but to reframe the relationship as 'my ex', a process that was interrupted by his death and that therefore kept her forever bound to talk about 'my late (husband)'. As the relationship was allowed to present itself through the narratives of their lives together, Mia could slowly find the courage to 'divorce' herself from a very abusive man, and Nancy could recommit to continue being the wife of her husband whom she continued to love dearly. Both these choices were natural and to some degree different from societal expectations. Both these choices brought relief.

With all the respondents in the study, it was clear that Narrative Therapy brought a lessening of the emotional distress of loss, better coping behaviour, increased insight and growth. More than expected, identity growth and expansion as well as making new meaning from life were observed. The themes, commonalities and some of shared experiences will be discussed in more detail below:

### **10.3 Emerging Themes**

As unique as the experience of loss and the many levels of growth that it required of the people in this study was, some experiences were shared. These common threads making up the rich tapestry of the grief experience is likely to be experienced by many other

bereaved people as well, and may shed light on this very distressing ordeal in human life for other therapists and counsellors in the field of thanatology and grief.

### **10.3.1 The Twofold Process of Grief Counselling of a Recently Bereaved Person**

No psychologically healthy person likes to see their loved one suffer. Moreover, sick bodies have smells, look pale and are different to a vibrantly healthy person. Furthermore, medical intervention is often a strange and seemingly harsh experience with drips and operations and needles and machines. The trauma of death and dying adds an experiential layer to grief counselling that is often overlooked.

Especially for the recently bereaved, such as with Cara, John and Nancy, it was noticed that there was a need to debrief about the trauma of the physical passing itself. For John, accepting and coming to terms with the days leading up to his son's suicide played over and over in his mind. He noted that for his wife, as a nurse, the impact of the crash and concerns that her son did not suffer caused her much distress. Cara in particular felt the need to talk in many therapeutic conversations about her father's last weeks. She was traumatised by the memories of him suffering, the loss of dignity and pain that he endured and the attitude of some of the medical personnel. For Cara, the smell of hospitals or driving on the roads close to the hospital brought on immediate upset and anxiety as she had flashbacks not dissimilar to a person suffering from post-traumatic stress disorder. Washing and dressing her father's body after his passing was confronting as she had to deal with the unpleasantness of operation wounds and blood. It was only after we discussed her experiences in depth, and sometimes re-storied the events noting the role she did play whilst her experience was that she was merely a helpless onlooker, that Cara overcame the trauma of her father's death.

Nancy's experience was literally brought home to her when her beloved husband came home to die. He was set up in the living room of the home they had built together and she was shocked by his emaciated frame after having always been strong and tanned. As

he struggled with pain and a deteriorating body, Nancy admitted at some point she wished for him to die, as she couldn't bear seeing him suffer so. When he did finally pass away, and the medical paraphernalia in their living room packed away, the space never seemed the same again. As a much more reserved person with a general striving not to offend, it took many sessions for Nancy to open up about this very distressing time in their marriage and how it affected her.

With Cara, John and Nancy, it was obvious that they felt that it wouldn't be socially acceptable to dwell on their sometimes disagreeable experiences, and so they struggled with private flashbacks and what could be seen as shocking thoughts. For all of them, having a non-judgemental, patient listener brought relief as they unburdened their memories in conversations without the need to censor, gloss over or beautify what was to them the worst thing to imagine.

It was only after these memories were allowed to surface and be worked through, that therapy could continue to the more important and usually longer phase of reconstructing a new life as they adjusted to the physical absence of their loved one.

### **10.3.2 Physical Symptoms**

Grief is a stressful time for most bringing with it a host of physical and mental experiences. Parkes (1998) discusses the physical impairments that commonly occur with grief which can include psychosomatic disorders such as aches and pains, increased adrenocortical activity and impairment of the immune response system.

All the people in this study noted a persistent sense of fatigue. Linda once wryly remarked that grieving is hard work, and it seems that indeed, being sad whilst trying to cope with the normal tasks of life and presenting a brave face to the world is quite taxing. Furthermore, sleep is often impacted and vivid dreams are common. Cara felt so

overwhelmed and drained, she couldn't go to work for months and only returned to half day after that. Linda found it hard to stay alert and on her feet all day and mentioned flopping into bed early at night, yet not waking up refreshed. Nancy noted that she had become quiet and too emotionally drained to go out and see friends or make conversation. John mentioned that his hearing was affected which he ascribed to a stuffy nose from frequent crying. He complained of nagging fatigue that persisted for more than a year.

A person who finds themselves entrusted with the feelings of a grieving person might find the opportunity to gently encourage regular nutritious meals and good self-care. Encouraging nurturing behaviour such as resting when possible and gentleness in caring for their own bodies gives the message that the life of the survivor is important and to be cherished.

It was interesting that Linda, John and Cara specifically mentioned loss of appetite, and initially eating food that made them feel worse, only to later become fairly health conscious. To me that indicated a renewed embracing of life and recognition that their own lives are precious enough to be taken good care of.

### **10.3.3 Depression and Other Difficult Emotions**

Hensley and Clayton (2008) quote various studies that found that, at two months after the death of a loved one, about 24% of the bereaved meet criteria for major depression, at a year after the death, about 15% of the bereaved are depressed, and at two years, the rate of depression is about 7%. Depressive symptoms of sadness and low mood are therefore quite common among the bereaved, though most find their mental equilibrium after about a year. The best predictors of the development of a chronic depressive syndrome have been found to be poor physical or mental health before the loss. The authors conclude that, though most people who experience the loss of a loved one

recover gradually without professional intervention, for those who become depressed and/or experience complicated grief, intervention is critical.

Beside depression, anxiety states, panic syndromes, and post-traumatic stress disorder are common experiences in bereavement, according to Parkes (1998) and suicide ideation may be present in many who feel that they have lost somebody they long for, though it is usually not acted on.

Most bereaved person's feel so overcome with sadness that they wonder if they'll ever heal and feel better again. It's not uncommon for the bereaved to idealise suicide and Stroebe, Stroebe and Abakoumkin (2005) in their study found that 'Heightened suicidal ideation in bereavement is associated with extreme emotional loneliness and severe depressive symptoms.' (p. 2178). Shortly after Cara's father died, she struggled with such sorrow and anguish she couldn't function or go to work. Cara lost her appetite and struggled to sleep. She was pale and looked fragile and tired, clearly overcome with sadness and prone to teariness. These symptoms are common experiences for someone who had experienced the loss of a person very dear to them, particularly in the months just following the death. One lonely evening Cara dressed in her father's pyjamas and took painkillers as she listened to her father's records. She overdosed on the medication and was hospitalised. Later she admitted that she just wanted to die and be with her father whom she missed so terribly she saw no point to engaging in life. This was a turning point for Cara who thereafter made a decision to live.

Shear, Frank, Houck and Reynolds (2005) discussed their findings about complicated grief and described symptoms such as disbelief about the death, anger and bitterness, pangs of painful emotions with intense yearning for the deceased, preoccupation with thoughts of the deceased loved one and avoidance of reminders of the loss. These are certainly emotions seen with all the persons in this study to varying degrees. John's anguish resulted in a diagnosis of depression by his GP, as did Nancy's. Mia's confidence was low



and her mood sombre and serious; and Linda struggled in her subdued way with intense sadness and missing her grandmother intensely. All of the grieving people in this study at some point expressed bewilderment. Anger was expressed by Cara at the hospital and doctors, by Linda about her grandmother, by John at his son, by Mia at her late husband and by Nancy at people wanting her to move on and date again.

Cognitive symptoms such as slowing of thought were noticeable with Cara and Nancy; and Linda reported struggles with concentration at work. John was struggling with constant ruminating thoughts, turning over and over in his mind questions about his son's last days and his motives for taking his own life, as if the answers would come if he kept thinking about it. This impeded his ability to think clearly and function optimally, especially at work.

#### **10.3.4 Grief as Social Construct – The 'Grief Police'**

Dennis Klass (1996) notes that all societies have rules about how the emotions of grief are to be displayed and handled. For some it seems natural to never talk about the person who died again, for some that seems completely wrong. For Klass, the most common mistake in cross-cultural studies of grief is to confuse the official worldview of the culture, its dominant mythology or theology, with what individuals in the culture actually do. Research on grief and mourning is descriptive: people describe what they do, but official theologies are prescriptive—they dictate patterns or norms of behaviour. An important point raised is this: the distinction between descriptive and prescriptive becomes somewhat muddy in contemporary Western society because psychology and sociology are the contemporary forms of myth. More often than not, research hypotheses are drawn from cultural prescriptions, and researchers' findings pass quickly into popular culture as prescriptions and directives. As psychologists and other caregivers of the bereaved we need to be aware that our descriptions, even in a study like this, can quickly be turned into 'shoulds' of how the process of grief should unfold or how to assist the bereaved. Our thoughts and well-meaning advice are equally informed by our

culture as social constructs and imply tacit descriptions and prescriptions of how, what and how long grieving should be.

This was particularly evident with four of the participants in this study: Nancy's GP expressed concern at every visit that she hasn't 'moved on' which left her questioning if there was something wrong with her. Nancy simply did not want to 'move on' and when well-meaning friends tried to set her up with single men, she felt she would betray the man she still felt married to. Implied or directly verbalised comments that she should have been feeling better by now brought a sense of failing to meet an implied social standard of how long a person should feel sad and miss the loved one that died. For Nancy who had always struggled with self-doubt, this attitude, though well-intentioned, diminished rather than increased her sense of self-efficacy. As the therapeutic conversations unfolded, Nancy slowly grew in strength and surprised herself with what she could do. When I recently spoke to Nancy she said that she continues to miss Tom every day and is still single by choice. But now, she has accepted that her feelings are not wrong or deviant and she functions very well in her world, despite missing her mate of thirty years.

Cara's family was aghast at their usually competent sister 'falling apart' and throughout the months of our therapeutic conversations, she was all but mocked for being 'crazy'. Like Nancy, Cara questioned why she was struggling so much and found herself disconcerted by unexpected feelings like anger and guilt. Her expectation of grief was definitely not of a struggle with what society would deem to be the less pretty emotions of the human heart. It was important that her feelings were normalised and accepted in order for her to heal.

Linda's husband became even more distant making her grief journey a very lonely one. He simply could not understand the emotions and her need to see a psychologist to talk

about them. To him, grieving was a private affair and he was baffled by her need for support.

Mia was outright accused on social media by her in-laws for 'being responsible' for the murder-suicide of her husband and son. She felt judged in so many of her actions and there were outright and implied accusations through social media that she didn't really care about her late husband. Her recovery was seen as further proof of selfishness. This substantially increased her distress in an already difficult time.

The only person in this study who did not seem to experience judgement of how he was grieving to a large degree by family or society, was John. Besides John, the other grieving persons in this study found their grief compounded and complicated by seemingly insignificant things like the sometimes insensitive remarks of others, adding another layer of sadness and bewilderment to their already overburdened hearts.

When members of the bereaved person's community, and that includes professional people, act like grief police, there seem to be rules about who and what you should grieve, what form this grief should take, and how long that grief should last. The fact is that every individual, and every relationship, is unique. Every grief is therefore also unique and unprecedented. When well-meaning friends or family seemingly act out of good intentions, it might also be a veiling of their own discomfort with difficult emotions. It is upsetting seeing somebody suffer and most of us may want to get the bereaved person to feel better, as their emotions bring discomfort to our own hearts. The fact is that when emotions are forced into a box of socially sanctioned grief, they leave the bereaved person lonelier in their distress and potentially crying alone where no one can see, judge or comfort. Be that as it may, whether born from social norms and habits, or personal discomfort in the face of somebody's distress, it seems to me that in a world which is not always kind, our compassion for those who suffer can go a long way to ease their suffering.

### **10.3.5 Many Losses**

When somebody dies, they leave a space they used to occupy by their physical presence, their voice, the conversation they brought to the dinner table, their contribution to the laundry load, sometimes their financial or practical contributions, the way conversations flowed differently when they were present. They might have been the person who used to put their music on and made everyone laugh with their offbeat sense of humour. They might be the patriarch or matriarch or the only child that made the adult a parent and without whom they don't have that practical role anymore. They might have been the person one thought of when you bought groceries or prepared dinner. They might have been the one who used to comfort and hold one when sad or tired.

When a person whom we love dies, it is not just the physical presence we miss. We miss how we felt in their presence. For Nancy that was feeling safe and cared for, for John that was feeling like a strong father, for Mia it was being the mom who took care of and laughed with her teenage boy, for Cara it was enjoying the music and laughter as the daughter of a father she always looked up to as a role model and friend, for Linda it was the sense of being part of a clan of strong, related women.

A family changes when a person dies. John was struck by how quiet the house had become and how he missed the lunch time phone call from his son. He noticed that dinners were different as they didn't need to consider what their son would like to eat anymore. He missed the role of father so much that he started to invite Luke's friends over and found himself mentoring young people. He lamented the loss one day when all the cousins got together, and Luke as the oldest of the cousins was not there to play with them anymore.

Linda's loss was multidimensional. Not only because she had lost three mother figures in the space of a year – her mother, great aunt and grandmother, but also because of how this changed family dynamics. As a family-minded person, it left her feeling disconcertingly alone. Linda missed the wonderful roast chicken and cinnamon pumpkin her granny used to make and going there for visits. She even missed buying her grandmother clothes or knowing that she prayed for Linda at night. Linda's loss caused not only sadness, stillness and fatigue, but she re-examined many aspects of her life. This impacted on her marriage and led to a sense of distance between her and her husband that was there before but was amplified by her grief experience.

It is not unusual for social dynamics to change as well. Nancy found herself at a loss in groups of friends consisting of couples who had been married for many years. She was no longer the one half of Tom and Nancy and mingling with couples seemed to have lost its easy togetherness.

The loss of financial security particularly impacted Nancy and Mia. Nancy had very little insight in the family finances which were all handled by Tom. After he died she had to learn quickly and eventually she sold the farm with the house they had built together and raised their daughters in. The loss of her home accentuated that the phase of her life as a married woman was over. Mia had a similar experience, though the loss of her home was quite sudden. She couldn't go in there after the murder-suicide and sometimes missed the kitchen where she chatted with Marko for hours. Her home had become a crime scene. Furthermore, debts her late husband had incurred put her under financial strain and worry in the months after her loss.

As much as it is tempting to believe that the many losses compound each other and make loss unbearable, it is interesting that sometimes these losses can force the bereaved person to deal with what is at hand, such as finances, and discover or develop

hitherto untapped skills such as negotiating financial deals or becoming a mentor for young people.

### **10.3.6 Identity Growth as New Roles are Incorporated**

When the writer C.S. Lewis' wife Joy died of cancer, he was not only devastated and lost, but also felt that his sense of self and of the world was devastated with it. In his personal recount of the experience in his book *A Grief Observed* (originally published in 1961), C.S. Lewis documented his struggle in raw honesty, and concluded: "Nothing will shake a man - or at any rate a man like me - out of his merely verbal thinking and his merely notional beliefs. He has to be knocked silly before he comes to his senses. Only torture will bring out the truth. Only under torture does he discover it himself." (2015, p. 38)

Calhoun et al. (2010) draw attention to the fact that posttraumatic growth often occurs in bereaved individuals even as negative emotions related to grief persist: "During this process, many people come to realise their own strengths, appreciate the impact of their relationships, and have new spiritual insights." (p. 125)

As a grieving person strives to make sense of his or her experience, there is opportunity for previous beliefs and assumptions to be questioned, and sometimes discarded. In addition, roles in the family and community change which bring fresh opportunities for growth and meaning-making.

It is important to remember that, though the experience of loss is highly personal and the relationship with the person who died unique, grieving and growing happens in communities of people. When something important happens in individuals' lives, they do not just think about it; they talk about it with others. They may also consult a psychologist, health professional or traditional healer who may be sharing the social

constructions of their community, which may influence how they make sense of the loss, and how they grow.

Making sense of the experience always happens in the culture, timeframe and community the bereaved find themselves in. A person might for instance see the passing as an act of God and surrender to that, or caused by a mistake by a treating physician leading to anger, or caused by witchcraft or voodoo causing fear. How the death is interpreted will also change how empowered or disempowered the bereaved see themselves. Furthermore, Narrative Therapy holds that identity is co-created in relationship with other people as well as by one's history and culture: a person's identity is socially constructed.

Klass observes that in the constructivist model "the purpose of grief is the construction of durable biographies—individual and social narratives—of the dead person and of the survivors that enable the living to integrate the dead into their lives. Narratives are stories. People make sense of their lives by telling a story that makes sense of their past and present experiences. Whether they are aware of it or not, people have an autobiography that they are constantly revising in light of new experiences. If something like an important death does not make sense, it is "nonsense." Both individuals and societies want to keep seeing the world the same way, but sometimes death forces one to see the world differently. When an individual sees the world differently, he or she constructs a new narrative, a new biography of themselves and of the person who has died." "Constructivist approaches to therapy adhere to the doctrine that ...(there is) the infinite ability of the person to deconstruct and reconstruct a new reality. (Biggs & Hinton-Bayre, p. 17)

Mia's story of her identity was informed by a man who saw her as lesser-than, as worthy of abuse, disdain and distrust. For years she was told that she was worthless and, although she didn't fully believe it, her journey of clawing her way back to self-respect

was a particularly harrowing one. Even before the murder-suicide, Mia had started to study after hours while working at a supermarket in the day, and slowly but surely she became stronger. She did not only have to overcome the barrier of language in a new country, but she had to remain focussed on her studies under intense pressure from a very controlling husband who did everything in his power to scare and humiliate her.

After the murder-suicide, a new struggle began. Mia did not want people to pity her. She knew instinctively that would keep her forever stuck in the identity of a victim. Yet despite her calm outward demeanour, Mia still had to let go of this identity when we met. The journey to an identity of a woman who is strong, capable and worthy of respect was a long one. Once she could fully embrace that role, Mia was able to fully construct an identity of a woman with artistic interests and a romantic soul: a woman who loved languages and travel and going out with her friends, and who knows, maybe would even consider opening her heart again to love.

When all three of her mother figures died, Linda found herself pushed to the outskirts of her family. She found this very hurtful and it forced her to re-examine the roles she had played in her family and in her life. As the one closest and probably most loved by her grandmother and the family member with most academic qualifications, there was probably a fair bit of underlying jealousy. But the rift between sisters and other females in the family preceded her by many years. In her profession as a registered nurse, and in her family, Linda embraced the role of healer. In the time of loss and family re-organisation, Linda naturally wanted to step in the role of the peacemaker again. After all, she loved everybody and had insight into their personalities. But she admitted upon reflection that this role was very draining and often ineffectual with old family habits. For Linda the solution was to expand the roles she typically took on by sometimes being caring and healing, such as with her patients, while at other times protecting her energy by not getting involved, and even exploring light-hearted fun in the company of her best friend.



Cara described the loss she felt as she suddenly realised that she was an adult orphan. From being her father's youngest daughter, after his passing she became painfully aware of a wide rift between her and her siblings. Unlike when her mother died, this time her father wasn't there to shield her from her siblings who seemed to be quite jealous of the close relationship she enjoyed with her father. Furthermore, Cara *"felt like the family pounced on my weakness and I was suddenly the 'mad one' in the family because I went on antidepressants and started therapy."* For her the roles she needed to change were a strange mix of the caretaker, the tough professional woman and the psychologically weak one. Cara had to define herself independently from her family and their expectations of her. In our sessions we explored shining moments when she showed resilience and determination, the professionalism she was lauded for at work, and the sensitivity mixed with strength which became her new way of being. The changing relationship with her siblings didn't come easily, but with persistence Cara did manage to change the roles she played in her family. In one of our last conversations she remarked *"I think my dad would be proud of how I handled things with the family, that I didn't become nasty but I also wasn't a push-over."*

Cara mentioned in our final therapeutic conversation that she noticed that she has become stronger and happier than she was in a very long time. Her priorities changed and she was much less concerned with money or as she put it *"glitz and glamour"*. She had decided to further her studies and she fell in love with a man she wouldn't have given a second thought to before her father died. In general, like Nancy's, Cara's confidence increased as well, not based on what others thought of her, but on what she has come to believe is important in life.

John found it all but impossible to give up his role as father. Instead he transformed it to mentor of Luke's friends and other young people. He frequently reached out to young men at work when he sensed that they were unhappy or struggling. The change in his role was in the transformation from father to a son to mentor and father-figure to many young people. He described his personal change: *"I'm a better person, I've done things I*

*would never have done, spoke to important people, gone to places I wouldn't have gone to otherwise. I'm more honest with my own emotions, also to others. It's not that I'm more compassionate, but I'm making more time to be caring."*

Nancy was always the 'second in command' in her family, with her husband Tom very much the one who steered the ship. She did not find joy in embracing widowhood and instead preferred to stay 'married' to Tom. Yet it was undeniable that she was now no longer in the same relationship with Tom: he was not there to make the big decisions any more, and she had to step up and take over the lead. Nancy struggled through the fear of making the wrong decisions and developed not just courage, but self-assertiveness, clarity in communication and fighting for what was rightfully hers. After a lifetime of being submissive and lacking confidence, her newfound assertiveness allowed her to grow in confidence and decisiveness.

### **10.3.7 Developing a New Relationship with the Deceased: Saying 'Hello' Again**

"Death ends a life but it does not end a relationship..." (Silverman and Klass in Klass, Silverman, & Nickman, 1996). Louise Hedtke (2010, p. 304) puts it beautifully: "...death may be understood from a postmodern perspective, and responded to, primarily as an event in a relationship, rather than primarily as an event in the life of a lone individual."

In this view, the relationship is not over, but changed. The person does not have to do the incredibly painful task of 'cutting the ties'. Rather, reconnection and reincorporation is encouraged as an essential part of healing through Narrative Therapy. "Focusing on what remains, rather than only what is lost when a person dies, has a therapeutic effect because it re-establishes a storied connection to those who have passed." (Hedtke, 2010, p. 6)

White quotes Myerhoff (1982, p. 111): "...full recovery from mourning may restore what has been lost, maintaining it through incorporation into the present. Full recollection and retention may be as vital to recovery and wellbeing as forfeiting memories." (in White, 1988, p. 17)

Indeed, it was clear that for the respondents in this study, being able, even encouraged, to talk about the people who died, brought relief as well as greater understanding of the complexities of their relationships. As therapists we are tasked first with being supportive and compassionate to the grieving person, and then to help them grow beyond the understanding that keeps them stuck, and potentially reframe the events and relationships they have and had. The remembering that takes place, brings the opportunity for what Narrative Therapy would call 're-remembering', in other words, the person who died becomes a member of the family, friendship group or community in a new way, playing new roles but maintaining a membership of the circle of people they used to belong to in physical form before. This reconstruction is very healing, as it gives permission to the bereaved person to continue loving and even communicating with their loved one, and the need to say goodbye in a harsh way falls away.

An important additional point to note is that the bereaved can become empowered to maintain, let go, or change the relationship with the person who died in a way that suits them. Mia was a striking example of this: she chose to maintain a relationship with her son and continue to hold the identity of his mother. Conversely, Mia decided to mentally divorce herself from her husband who committed many cruel acts culminating in the murder of her son. She moved from calling her late husband her "*late*" to calling him her "*ex*" and changed her surname back to her maiden name.

Sometimes the narratives that are remembered need to change, as happened with John: John was very stuck in remembering the days before Luke died, trying desperately to understand what was going through his son's mind, and how he could have prevented

his suicide. In our therapeutic conversations John was gently encouraged to bring a richer description and more stories about his son's life into our conversations. Eventually, the emphasis naturally shifted to happier narratives, shining moments in their time together, times when both he and Luke were at their best. This enabled John to remember Luke as a healthy, mischievous and normal young man rather than over-focussing on his death with all the harrowing emotions that accompanied those thoughts. By the same token, it relieved John from the burden of the identity of a father whose son committed suicide, to the richer and more accurate identity of a father of a son. When that became possible, John could build on his experiences and continue to be a father-figure to many young people. John's story of grief opened up from a singular story of suicide to the richness of multiple stories they shared.

A similar process applied to Linda. Linda was encouraged to explore the richness of her beloved grandmother's character. In doing so she changed how she related to her – at first Linda had a romanticised view of her grandmother which later turned into disappointment as she remembered her grandmother's stubbornness and the effect this had on the family relations. For a few weeks Linda struggled with thoughts of "*how could she?*" and her internal conversations with her grandmother changed to questioning. Relief was found towards the end of our conversations in a realistic and loving acceptance of her grandmother as a human with flaws and strengths. As Linda acknowledged her grandmother's full identity, she related to her in a different way – Linda looked at her as a fellow woman, flawed but very loved. In this way, Linda could continue her relationship with her grandmother in an easy and natural way through the rest of her life.

### **10.3.8 Resilience**

Surely the person who first thought of the myth of the phoenix must have known someone who had gone through the fire of utter pain to rise a new creature on the other side. Experiencing intense grief can feel like dying. It is often bitterly painful to let go of a loved one, one was once close to, and in addition letting go of the roles one embodied

or the rituals and habits one shared. It is not uncommon for a person overwhelmed by grief to feel like dying themselves, as Cara did, or to find themselves stripped bare by pain. What continued to surprise me was that all of the grieving persons I have worked with in my practice spanning two decades, recovered to a large degree from the intense pain. At some point the urge to look back, cry, and search for what is lost, is overtaken by the practicalities of what remained and a growing impetus to look forward, explore the world that now emerges, and discover what can be carried forward from the past. Humans are nothing if not adaptable. What struck me was that all of the people I worked with were changed subtly, or dramatically, by the experience.

A striking example in this study of unexpected resilience was by Nancy who had spent her adult life relaxing in the trust she had in her husband. He handled all their affairs, made most of the major decisions, paid the bills and did the online banking. When he died, Nancy did not believe she would cope at all. She was surprised when she rapidly learnt new skills and became au fait with legal terms in water disputes with a neighbour and so on. Eventually she had taken on most tasks she used to rely on her husband for, and surprised herself with her resilience.

The person in this study who without a doubt endured the most gruelling trial, Mia, whose husband stabbed their son to death before taking his own life, had a much harder task than most who lose a loved one. Mia's loss was compounded by a number of factors known to increase trauma after death (Parkes, 1998): she had lost her son, a very distressing experience in anybody's book; because most of us have a sense that parents should die before their children. Moreover, the loss was sudden and unexpected. But what was particularly upsetting was that her son was murdered by his father, in their kitchen. It was an almost incompressible act and therefore took a long time to accept, much less make sense of. Added to that a complicated relationship with her late husband after years of abuse, the guilt about the events leading up to the deaths, verbal abuse from family members and her status as an immigrant and one would assume Mia would surely fall to pieces. But she did not. She kept going, and slowly but surely, piece

by piece, built a new life. What helped were her innate strength and determination, her faith, and the support by members of her community such as her manager, friends and members of her church. Mia also sought help and was willing to explore her feelings and the experience until she came to acceptance and healing.

### **10.3.9 Spirituality and Religion and the Potential for Finding Comfort and Meaning**

Spiritual beliefs and practices have been shown to increase a person's ability to cope and heal from distressing events. Furthermore, they provide the potential to draw positive meaning from the loss according to Folkman (1997) and Jacobs et al. (1994). Calhoun and Tedeschi (2000, p. 167) agree that religious and spiritual beliefs have been observed to be one way in which individuals create meaning and a sense of order and purpose after the experience of trauma.

For Cara, the grieving process brought the opportunity to think differently about the physical and metaphysical world. She reflected and read about philosophical and spiritual issues and told me that this has helped her to think of her father's death not as "*senseless but meaningful*". For Cara, her books and thoughts about spirituality and the afterlife brought a sense of increased intuition and an unshakeable belief that life went on for both her parents. This gave her great comfort and strengthened the idea that she could continue her relationship with those who had died, even if not in a physical form. She found solace in her dreams of her father and the conversations she kept having with him in her mind. These thoughts seemed to help Cara cope better with the physical world as her usual common sense ways returned, softened by the grief experience and the growth that had taken place.

Church was a contentious issue in Mia's marriage, her husband, a Croat, wanted her to convert to the Orthodox Church, but she refused as she felt more at home in the Catholic Church she had grown up in, that was also part of her Croatian cultural background.

Even before the death of her husband and son, Mia's local church provided a safe haven from the world and her marriage. Afterwards the community of the church as well as the belief in something larger than herself gave her comfort. She attended church regularly and it was not uncommon for Mia to make short references to God or spirituality in our conversations. It was interwoven with her character, and through all the many changes of her life, it was a constant. In the time of our therapeutic conversations, Mia did a Christian course over several weeks to learn and grow more. In essence Mia's faith didn't change because of the experience, but her faith deepened and became less complicated without her husband. There was a sense of this is who she is, and that belief helped her anchor her identity in something she found solid and steady. When she felt she didn't understand how the man she married could do something so utterly cruel, she surrendered to the belief that, even though she might not understand, it must be part of a greater plan and she could accept it.

Growing up with her grandmother who was a staunch church-goer, church and Christianity was a natural part of Linda's life and psyche. Cultural beliefs and an unquestioned conviction that our forefathers go on, was part and parcel of her background and implied in her thinking as three mother figures died in short succession. As she grew older, Linda's faith was influenced by the spirituality of her best friend. For Linda, incorporating different belief systems into a coherent view of how the Universe worked was as natural as breathing. There was no doubt in her mind whatsoever that her mother, great aunt and grandmother lived on, and that belief gave her comfort in the fact that it wasn't the final goodbye. How much they were still involved in her life she wasn't sure about, but that they lived on and she would see them again one day, was a given to Linda. This provided solace when she missed them, and a sense of belonging to a clan of strong females, some of them dead, some alive, but all part of the same family.

In a similar way to Linda, John's beliefs consisted of a mixture of Christianity and spirituality. He was convinced that he felt his son around him by sensing a smell of him in the car or seeing blue Combis on the road that was one of Luke's favourite things. Like

Linda, the firm belief that his son is alive and relieved from his suffering, brought a great deal of solace. Also, trusting that he will see Luke again one day helped John to focus on what tasks he felt he still needed to do while alive.

### **10.3.10 Finding New Meaning in a New Life**

Ralph Waldo Emerson once wrote: "When it is dark enough, men see stars." (in Tomer, Eliason and Wong, 2007: p. 381). Indeed, from the pits of darkness grief sometimes throws us in, new and unexpected meaning can be found when we can find it in us to transcend our own despair.

Victor Frankl is perhaps the most well-known proponent of the theory that suffering can lead to growth. His book *Man's search for Meaning* was published in 1946 after surviving the holocaust. Frankl believed that people are primarily driven by a striving to find meaning in one's life, and that it is particularly this striving for a sense of meaning that enables people to overcome painful experiences. Even suffering can be meaningful, he concluded. He is quoted as saying, "What is to give light must endure burning" and "Those who have a 'why' to live, can bear with almost any 'how.'" (Viktor Frankl Institute Vienna, 2011). Porter (2003, p. 104) calls suffering 'the crucible of transformation': "Suffering creates a crucible in which old aspects of the self deconstruct so that new dimensions and possibilities can arise."

When we lose someone of significance to us, it throws our worldview and life view in turmoil. We may start with questions such as 'What did this person mean to me?', 'How will I cope and live without him or her?' and soon we may move on to 'What does death mean?' and 'What does my life mean?' Asking the difficult questions of life can bring an existential crisis for some, soul searching for others, but usually at the very least it changes how we view what is important in life and what is meaningful to us.



We find meaning from that which we find meaningful. As such it is both a highly individual experience as well as one that is seated in the socially constructed world the person moves and lives in. It is in the interaction with our world, and from a sense of authentically expressing our purpose within it, that a sense of a meaning develops. This sense does not presuppose a sense of happiness, which is often implied in therapy goals. Indeed, it seems that going through very sad experiences in particular yields the opportunity for new facets of our character to develop which help us to construct a narrative of meaning after loss.

A sense of living a meaningful life is often gained from a belief that your contribution to the world matters. Beyond healing, and even personal growth, I was struck by some people touched by loss who take it further, who somehow find the strength to give back. This seemingly originates from wanting to take what was learned and teach others, or from the sense of how much being cared for in a time of emotional need can mean. Perhaps it is also a way of paying forward the kindness that was shown to them when they needed it. In his book *Staring at the Sun: Overcoming the Terror of Death* (2009), the well-known psychologist Irvin Yalom writes that, as we are confronted by mortality, we are inspired to rearrange our priorities, communicate more deeply with those we love, appreciate more keenly the beauty of life, and increase our willingness to take the risks necessary for personal fulfilment. On page 130 he writes: "The lesson here is simple: connection is paramount."

To my mind it is a courageous act to not let the pain and loss swallow one whole after a loss, blame others or God, or use the loss as an excuse for inaction but rather courageously lift your head and aim higher. Making meaning from loss is not a quick Band-Aid to feel better, although of course it may ease pain. It involves honest soul-searching and probing for life lessons and gifts in the ashes left behind by the relationship that once was. It cannot happen too early on in the process while the pain is still raw, then it is more likely to be a way of denial or escaping the pain. Making true

and deep meaning happens much later, once the lessons have been learnt and the experience has made one humble, and compassionate.

John inspired me with his ability to give even as his heart was filled with sadness. When his son died his first focus was to support his wife Emma through her grief. Months later when she started to heal, John found himself floundering as he made his way to me. He felt lost and his life seemed to be without purpose. Later, John began to find meaning and purpose in the volunteer work he started almost a year after his son died. He became involved in charities that support people at risk of suicide, raised funds through organising events, and became an active proponent of a supportive group for the mostly male employees of his company that encouraged communication of difficult emotions. Despite a fulltime career, John gave of his time on weekends and weeknights and did everything in his power to prevent suicides. Informally, he found a worthwhile reason to keep going in being a mentor, helper and father figure to Luke's friends. In one of our last conversations John said that he had become a better and more caring person whose awareness about young people and their emotions was raised after his son's suicide. He developed more compassion and used his insights not to berate himself for not doing more to prevent his son's suicide, but channelled it to preventing others. In answer to the question what his life was about – that was it: to help others.

Cara found that her father's death plunged her into despair and questioning her place in her family and the purpose of her life. She had been the main organiser of her father's medical care and after his death she found herself at a loss – she didn't have the task of meeting with doctors and driving to the hospital anymore, she felt she had lost her companion and best friend, and she felt no motivation to continue her work. Her emptiness found expression in a half-hearted suicide attempt one lonely night. That was the turning point for her – she decided to live, but still needed to find something to live for.

As she questioned why she had been through the experience through the lens of her expanding spirituality, Cara explored if the growth that could come from the trauma could give her a clue about her life in the future. Her natural caring nature had been abused by others in the past, but she wanted to explore how she could steer this trait consciously to live a fulfilled life. Cara did not change her career but decided to study further so that she could move to a managerial role. We discussed her values and she reaffirmed how grateful she was for what her parents had taught her as she grew up. Before her father's cancer diagnosis, Cara was enjoying what she called the "*glitz and glamour*" of life. About eight months after his death, Cara noted that "*money means nothing in the bigger scheme of things*" and that she would like to help others and give back. This thought remained with her during our last therapeutic conversations, and although she didn't make any dramatic gestures, Cara became markedly softer and more generous of spirit in all her dealings.

Sometimes a person comes to a sense of purpose through realising that life is not purely about surviving, but about living. Throughout Mia's marriage and the years following the deaths of her husband and son, it was as if she was on autopilot. She managed the practicalities of life, went to work, paid her bills, even got promotions at work, but she continued to feel like a "*small doll in a big storm*" and at the mercy of a very vindictive husband's whims. It was only through changing how she related to her husband that she managed to free herself from this bondage and could start growing freely. Before her son died, Mia found meaning and purpose for her life in caring for him. After his death, life seemed very empty. Many years after the tragedy, we discussed what was important to her and reflective of her true nature. Mia particularly found meaning through her faith and her paintings. These may not seem like grand gestures, but for a woman who had gone through oppression almost all her adult life, being able to freely express and freely worship were no small feats. Life was more colourful and more grounded and Mia felt more alive for the first time in decades.

## **10.4 Conclusion**

This qualitative study explored the in-depth experiences of bereavement of five diverse adults. All of them found the experience highly distressing, probably the most distressing experience of their lives. The aim of this study was to emphasise that talking with a compassionate therapist through the emotions and experience of loss, is only the first but crucial step in grief counselling. Social, career and personal functioning can and has been shown to improve by utilising the approach and techniques of Narrative Therapy. The study has shown how important it is to re-member the deceased loved one in the circle of family and friends, and how natural it is for a relationship with the deceased to continue, or to be transformed, at the will of the person who remains alive.

Of particular note however was that all the participants did not just show benefits in terms of their emotional wellbeing: this study has also shown that from the death experience, sense can be made, growth can happen and a bereaved person's identity can develop and change. I believe that what particularly makes the grieving process significant to the individual is this growth that takes place. In all the cases studied here, mourners have grown, discovering or expanding aspects of their character they did not realise they possessed. Interestingly, sometimes characteristics and skills came to the fore which were previously possessed by the deceased. Sometimes the roles the deceased person played were to some extent incorporated in the identities of the survivors. Calhoun et al. (2010) describe the growth beautifully in the paradoxical phrase "more vulnerable, yet stronger" (p. 127). And indeed, all the participants in this study described persistent fatigue, disrupted sleep, deep sadness and cognitive impairments. Ironically, all of them were surprised to also discover inner strength, tenacity and a will to continue living.

An important development in their journey of healing was a newfound sense of meaning and purpose to their lives that the respondents found from the heart-break, a testament to the strength of the human spirit. Sometimes it was found in art or spirituality,

sometimes in giving back to the community, for some the growth in themselves brought the meaning.

It seems clear that if a bereaved person's grief experience is approached with compassion, acceptance and the willingness to explore all the nuances of the experience, the relationship with the person who died, and the potential post traumatic growth that can take place, grief can be a transformative experience leading to identity growth and meaning.

## **Chapter 11**

### **Conclusion**

#### **11.1 Introduction**

Social research typically falls in two camps based on two sets of paradigms: positivist and interpretivist (Hancock, Windridge & Ockleford, 2007). In the positivist approach, the methods of research are based on those deployed in the natural sciences and may include experiments and surveys where quantitative data and deductive reasoning is the norm. With an emphasis on observation and reason as means of understanding human behaviour, knowledge or information is obtained by observation and experiment. Cohen et al. (2000) note that the assumptions underlying this research are determinism, empiricism, parsimony, and generality. Determinism means that events are caused by other circumstances and therefore causal links are examined in the data. Empiricism means collection of verifiable empirical evidences in support of theories or hypotheses. Parsimony refers to the explanation of the phenomena in the most economical way possible. And perhaps of particular interest to this study – generality is the process of generalising the observation of the particular phenomenon to the world at large. Patterns and regularities are thus searched for with the aim of generalising them to people not in the study. Researchers with this paradigm in mind strive for objectivity and distance between researcher and those being studied to avoid bias as far as possible. The research is typically based on a hypothesis that the researcher starts out with which is tested in the form of numerical assessment, statistical analysis and the search for cause and effect.

Positivism is to a large degree based on the belief that reality exists outside and independent of the researcher, while interpretive – descriptive, social research, is based on the assumption that social reality is constructed and does not exist independently from the people who are creating it.

The interpretivist view can be linked to Weber's 'Verstehen' approach – that is, an empathetic understanding rather than an objective observation. The 'Verstehen' method (literally 'understanding') has as its aim an empathetic understanding of something in its context – not in the intuitive feeling-with sense, but as reflective reconstruction and interpretation of the actions of others. Thus, the methodology centres on the way that human beings make sense of their subjective reality and make meaning of it. (Hancock, et al., 2007) Myers (2008) explains that interpretive researchers believe that access to reality (given or socially constructed) is only through social constructions such as language, consciousness, shared meanings, and instruments.

Qualitative researchers therefore work from the assumption that the experiences of people are context-bound – they cannot be free from the time, location or the mind of the experiencer, and therefore the world is socially constructed and should be studied as such. Complete objectivity and neutrality are impossible to achieve and the researcher's values and views are not divorced from the phenomenon under study. Whereas quantitative research typically starts off with a ready hypothesis, in qualitative research the theoretical framework is not primary but derived from the data as data collection and data analysis proceed concurrently.

My opinion is that it is not an either/or debate with research, with both camps glaring suspiciously at the other. To my mind the type of research question should inform the type of research paradigm that is followed. I felt that qualitative research is more respectful of a grieving person's experiences in a time when their hearts are broken and their worldview shattered. It seemed almost cruel and heartless to ask a sad and distressed person to fill in a questionnaire of symptoms. I felt more comfortable with rather aiming to gain a deeper understanding of the grief experience and what happens for the person because of it. Furthermore, it is my belief that this experience cannot be reduced to a list of symptoms, and studied as such.

Importantly, I did not want to use participants to provide data for my purposes which would have no value or interest for them. I feel myself a therapist first, a researcher second. For me the research should happen in a natural setting where grieving persons felt safe and could trust that they would be treated in a way that would be in their best interest, not mine.

## **11.2 Strengths of the Study**

This qualitative study incorporated the classic elements of interpretivist research: a small sample was purposively chosen to illuminate and investigate a contemporary phenomenon within its real-life context. The emphasis was on a detailed contextual analysis of a limited number of grieving persons, their relationships, emotions, experiences and identity growth. As typically happens with case study research, the process involved a moment by moment gathering of data and theorising. The aim was not merely to list apparent symptoms or make correlations, but rather to obtain deeper and **richer data such as the meanings that individuals assign to events, the complexity of their attitudes, behaviours, experiences and relationships, and their personal identity growth.** Hancock et al. (2007, p. 13) quote Denzin (1989, p. 83) who describes the richness of the data as “deep, dense, detailed accounts of problematic experiences... It presents detail, context, emotion and the webs of social relationship that join persons to one another.”

As such, the first and most noteworthy strength of this study is that it brought a deeper and more nuanced description and understanding of a process that can be complex, full of paradoxes and facets. As such, the hope is that it will **expand knowledge and add breadth and depth to what is already known through previous research.** It is hoped that, as sometimes happens when qualitative researchers give detailed descriptions in their case studies, that the reader will understand the path and process of the study, grasp the way the conclusions were arrived at, and perhaps develop a form of



experiential and even compassionate understanding for the world and experience of the bereaved.

The knowledge and interpretations from this study are necessarily **emic** as the researcher is also the therapist and is likewise a native of the culture. I purposively looked "at things through the eyes of members of the culture being studied" (Willis, 2007, p. 100). Whilst this may reduce objectivity, I believe an outsider's perspective can never fully capture what it really means to be part of the culture or indeed the specific therapeutic process. The complexity of the grief experience lends itself well to this kind of research which explores "the views, perceptions, meanings and interpretations" of the people involved in the research (Hancock et al., 2007, p. 10). Rather than impose their own framework on the persons and topic under study which might distort the narratives of the participants, a qualitative researcher aims to "'uncover' the meaning people give to their experiences and the way in which they interpret them" (p. 12). The researcher then searches for patterns in process and interaction, or the invariant constituents of the phenomenon being researched. The advantage of this approach is that better access is gained to the social reality of the participants. Furthermore, the participants are empowered and given a voice in the study.

Denzin & Lincoln (2005, p. 2) describe it this way: "**Qualitative research is a situated activity that locates the observer in the world.** It consists of a set of interpretive, material practices that make the world visible. These practices transform the world...This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them." This approach has the benefit that it brings greater insight into how the context of the grieving person affects him or her as they are grounded in temporality and location. Understanding the context means that the actions, perceptions and motivations of the individuals under study are better grasped. It also contributes to a better understanding of what is individually significant.

The research model chosen enabled the researcher to be both therapist and data-collector. This allowed inquiry and theorising to take place whilst therapy is in progress. Information was thus obtained through a process of **active moment-to-moment theorising, data collection and content analysis**. Descriptive research looks at the questions of why, how and what is happening, rather than search for correlations. This way of doing research has the benefit of being open to whatever arises without the constrictions of a narrow expectation which might make it easy to miss other important and relevant data. In this study a greater sense of the therapeutic value of Narrative Therapy in bereavement therapy arose which, although it was investigated in broad categories, such as identity growth, was still open to the many nuances of therapeutic outcome. A full and rich description of each individual's experience can illuminate the complexity, intricacies, and multi-layered nature of the actual lived grieving experience. The aim was to describe the nuanced complexity of the deeply human experience of grief without reduction, in terms of the individual's own frame of reference, and so bring a deepening of comprehension for clinicians and people faced with grieving individuals. To minimise therapeutic growth to a few scores on a questionnaire would certainly have missed the depth and breadth of how the therapeutic experience can change a person in so many spheres of their lives.

A qualitative study often means that **the relationship between the researcher and researched is one of closeness and equality**. This seems to naturally fit the field of Psychology or for that matter any of the disciplines that involve caring for and healing of people in need. In Narrative Therapy the therapist is a compassionate and committed ally as well as co-author with the client which here is also the subject of the research. That means they co-write the narratives that make up the results. The perspective is typically person-centred and holistic and aims to understand the human experience in depth through a compassionate, non-judgemental in-depth study. Not only do I believe that it is more respectful to the person being studied who is by definition the expert of their own lives, but it fosters greater trust which might facilitate more full and authentic participation.

Qualitative enquiry **can trace progress and development over time**, as perceived by the participants as well as the researcher. A qualitative researcher immerses themselves in the world of the person they study, “observing, questioning and listening” (Hancock, et al., 2007, p. 12). This means that a researcher-therapist can see how a bereaved person grows through different emotional states and experiences and the research may even serve as a record of a new emerging identity. “... narrative research is interested in how the events of life impact upon the individuals who experience them. It is the relational space between the experience and the meaning that is of interest, not just the event itself or the outcome.” (Hedtke, 2010, p. 197).

### **11.3 Limits of the Study and Suggestions for Further Research**

As with all research, limitations brought about by the scope of the study, the paradigm and methodology, even the time frame and contextual bounds, are inherent and influence the outcomes. Exploring the limits of this study will hopefully spark ideas how it may be improved in future research.

The most obvious limitation in this study was that it was **qualitative, not quantitative**. That means that the results may not necessarily be generalised to the wider population of all grieving humans. The findings may be difficult to replicate especially as every therapeutic experience is necessarily variable and unique. Because case study research is based on the analysis of qualitative (that is, descriptive) data, a great deal depends on the emphasis the researcher places on the information that has been acquired. Furthermore, because of the subjective nature of the study there is more scope for observer bias. The goal with qualitative research however is not to generalise, but to bring a clearer understanding of the information-rich lived experience and yield in-depth information that may inspire further research.

I agree with Bryman (2001) that qualitative and quantitative approaches are simply different methods of social research that yield complimentary information and that

should be used pragmatically, dependent on the research question. The process of triangulation is an example where several data collection methods yield information that can be used to confirm or compliment the different sources (Hancock, et al., 2007).

A suggestion for a quantitative study is utilising the *Posttraumatic Growth Inventory* (PTGI) which could be useful to yield complimentary information in this field, and could be completed by more respondents. The PTGI is an instrument for assessing positive outcomes reported by persons who have experienced traumatic events. It consists of a 21-item scale which includes factors such as New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life (Tedeschi & Calhoun, 1996).

The **study participants** were chosen to illuminate and provide rich descriptions and understanding of a variety of individual experiences of grief. The in-depth information it yielded was invaluable, but if a larger sample size were investigated, more robust support for the conclusions might be found, as well as further nuances and implications for utilising Narrative Therapy to bring about identity growth.

The **cultures** studied were out of practicality limited to South Africans visiting a psychologist practice in Johannesburg. Although there are certainly overlaps with many other descriptions of grief, the basic tenets of Narrative Therapy such as remembering stories of shared lives, and many remembering practices, although culturally influenced, are assumed to be universal. Further studies into utilising Narrative Therapy in different cultural settings might be able to shed light on this.

In this study one participant was a black South African; the other four were white South Africans. All the participants have obtained a minimum of year 12 level of education with some further studies and could be described as middle class. As a white South African I shared some commonalities and some differences with the participants. I was not

aiming for complete neutrality. Clearly my understanding of certain cultural concepts such as honouring the forefathers and thereby having a specific continued relationship with them can never be fully grasped by someone not immersed in a black family's upbringing. Further in-depth studies would elucidate this and add to the body of literature.

The language of grief is bound to be influenced by the **language** spoken in therapy – in this case both English and Afrikaans. Narrative Therapy is based on the stories we tell about our past, our present and our foreseen future. The stories are not enacted or danced, in the therapeutic setting of this study, they were told. As such, the stories took shape through language which in its own right shapes the stories. How much the language influences the way stories are narrated is surely difficult to explore, but it raises an interesting philosophical question.

In the span of a lifetime, I was honoured to be let into the deepest thoughts of the participants for a space of time equivalent to months. Who knows how the decades afterwards were influenced by the grief experiences? Or for that matter, how the families of the bereaved were touched in the long run by the therapeutic intervention? The **time frame** of this study was limited out of practicality. Longitudinal studies of identity growth through the process of bereavement would be fascinating – did the experience change the course of the participants' lives?

The **researcher was also the therapist**. As far as possible throughout the study I strove to be as objective as far as possible, but clearly, replicability is influenced by not only the therapist, but the unique relationship between two people – therapist and client. I held a personal bias towards the project and the participants: I wanted them to get better and of course I did my best to be helpful to them. Did the therapists lead the growth? It was impossible for me to enter into the research from a neutral position. Further research is

needed with various configurations of therapists, facilitators and researchers to investigate whether this bias negatively impacted upon the study.

Like any therapist, I too was born in a time frame and culture, and cannot deny that my concepts of grief or even therapy in its simplest form, are informed and shaped by the social constructs I may or may not be consciously aware of. So as a **child of my time**, and as postmodern human, I need to maintain the same humility as researcher and therapist as I would expect of any other.

#### **11.4 A Personal Reflection**

I am humbled by the experiences I have been granted. To share in the stories so close to the heart of the people I was honoured to get to know, is a privilege I will never take lightly. This is true for me as a therapist in general. A therapist has a privilege and yes, a responsibility, to tread carefully with the heart of the person who is in need and in pain. I am so very grateful that I have been entrusted with the hearts of the participants in this study, and so utterly blessed to have been able to make a difference to their lives. For the people I never met but through the remembered stories of their loved ones - those who had died - I feel like I know you. Through the eyes of those who knew you in person, I have received rich descriptions of your personalities and lives, and I give a silent thank you to you too.

I too have grown through this study in ways that are not easy to quantify. Is personal growth ever truly measurable? Certainly, I have grown intellectually, and I am a better therapist, but mostly, I believe I am a better human.

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## APPENDIX 1

### Consent Form for Bereavement Study

I understand that I am consenting to be part of a study about bereavement and Narrative Therapy conducted by Marie-Jeanne Bukman-Kruger. It is my understanding that the therapy sessions may be transcribed and used as part of Marie-Jeanne's PhD study named *The Development of a New Identity through the Process of Bereavement Counselling: A Qualitative Study*.

I hereby give consent for her to use the information that may arise from our sessions, with the caveat that all information will be strictly confidential and no clear identifying particulars will be used that may identify myself to anyone known to me. I furthermore understand that she will at all times aim to give me the highest quality of care, and that the therapy would not be compromised in any way by the study.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_